COMMUNITY MENTAL HEALTH CENTERS—OVERSIGHT

HEARINGS

BEFORE THE

SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

NINETY-THIRD CONGRESS

FIRST SESSION

ON

OVERSIGHT OVER THE ADMINISTRATION OF THE COMMUNITY MENTAL HEALTH CENTERS

MAY 9 AND JUNE 15, 1973

Serial No. 93–39

Printed for the use of the
Committee on Interstate and Foreign Commerce

U.S. GOVERNMENT PRINTING OFFICE
21-333 WASHINGTON : 1973

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COMMUNITY MENTAL HEALTH CENTERS—OVERSIGHT

WEDNESDAY, MAY 9, 1973

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2218, Rayburn House Office Building, Hon. Paul G. Rogers, chairman, presiding.

Mr. ROGERS. The subcommittee will come to order, please.

This morning the Subcommittee on Public Health and Environment is conducting oversight hearings on community mental health centers, a program initiated by the Congress in 1963. The original goal of the program was the establishment of 2,000 federally supported community mental health centers in virtually every geographical area of the United States in order to cover the population of this Nation.

Although the goal of the number of centers needed has been changed from 2,000 to 1,500, the original goal of the legislation—that every citizen of the United States have access to the services of a community mental health center, initiated, if necessary, with Federal assistance—has not changed. This goal is now one-third complete, as there are approximately 500 centers in existence.

As you know, the budget recommendations of the present administration call for termination of Federal seed money for the construction and initial staffing of new centers. The rationale for this recommendation appears to be based on the assumption that the community mental health centers program was a demonstration program.

As one of the principal authors of the original legislation, I want it to be clear at the outset of this hearing that the community mental health centers program was never intended to be a demonstration program, and any arguments to that effect have been effectively refuted during previous hearings conducted by this subcommittee and the Senate Health Subcommittee.

Most importantly, the legislative history of the Community Mental Health Centers Act refutes this claim. Although the funding of individual programs was to be limited to a certain number of years, the number of newly initiated centers to be federally supported has always been fixed at the number necessary to cover the population of the United States.

This morning we will hear from representatives of the Department of Health, Education, and Welfare and a panel of directors of community mental health centers.

Our first witness is Dr. John S. Zapp, Deputy Assistant Secretary for Legislation (Health), Department of Health, Education, and Welfare, accompanied by Dr. Bertram Brown, Director of the National Institute of Mental Health, and Dr. Saul Feldman, Associate Director, Division of Mental Health Service Programs at NIMH. We welcome you gentlemen to the committee and will be pleased to receive your statement.

STATEMENT OF DR. JOHN S. ZAPP, DEPUTY ASSISTANT SECRETARY FOR LEGISLATION (HEALTH), DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. BERTRAM S. BROWN, DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION; AND DR. SAUL FELDMAN, ASSOCIATE DIRECTOR FOR COMMUNITY MENTAL HEALTH SERVICES, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Dr. ZAPP. Thank you, Mr. Chairman and members of the committee. My testimony today will be brief, as this subcommittee has had a continuing interest and involvement in the community mental health program. There thus is no need for me to restress the acknowledged value of community-based care as opposed to isolated institutionalized treatment.

ADMINISTRATION'S HEALTH STRATEGY

We have not felt, in developing our present health strategy, that our only choice is to cling to the patterns of the past. Instead, we have tried to define carefully a proper Federal role in health and then to measure various individual proposals for Federal intervention in terms of this definition. Briefly, as we have discussed previously with this subcommittee, we feel that first priority should be placed on reducing financial barriers that limit access to needed health services. This is primarily accomplished now through the medicare and medicaid programs; it will be furthered by enactment of a sound national health insurance program on which we will soon be making our recommendations to Congress. While we are not in a position to discuss the details of our still-developing proposal, we can state at this time that it will have a mental health component.

In our view, Federal support should also be provided for health and medical research and many preventive health and consumer protection activities are appropriate Federal concerns in the collective national interest. A more limited Federal role and increased reliance on the capabilities of local public and private sectors are, however, indicated in certain other situations, such as the demonstration of new facilities or services or startup funding for their establishment. Any such programs should be time-limited and should incorporate from the outset feasible plans for permanent takeover financing from alternate sources. This strategy reflects our conviction, as expressed by Secretary Weinberger before this subcommittee on March 1 and again on March 29 of this year, that not every worthwhile health program can automatically become or remain the financial responsibility of the Federal Government if we accept our obligation to maintain a fiscally sound Federal budget.

COMMUNITY MENTAL HEALTH CENTERS PROGRAM—HISTORY

Against this backdrop, let us examine the Community Mental Health Centers program. In 1963, the concept of community-based care for the mentally ill was an idea whose time had come. There was mounting evidence that the mentally ill recovered more quickly and with a far lower emotional burden on their families and loved ones when they were treated in their home communities. For 10 years, the Federal Government provided support, first for construction and later for initial staffing costs of community mental health centers to demonstrate the viability of the concept. By the end of this fiscal year, the Department will have provided financial support for the development of over 500 community mental health centers across the Nation.

DECISION TO PHASE OUT DIRECT CENTER SUPPORT

The value and effectiveness of innovative community mental health centers have now been amply demonstrated. These centers can and will continue to play a very important part in the management of emotional illness. However, it is time to shift the responsibility for developing and operating such facilities to State and local agencies which must ultimately bear the major responsibility for the direct provision of public health services of all kinds.

Our decision to phase out support for community mental health centers is consistent with the philosophy which underlies our health strategy, that it is appropriate to underwrite promising new methods of health service delivery, but only until their feasibility has been proved or disproved. As the Secretary said before this subcommittee on March 29, 1973, in announcing that the Department is not proposing extension of the Community Mental Health Centers Act but will continue to honor its commitments to existing centers, "The need for federally funded demonstration has been met."

FUTURE OF THE PROGRAM

We believe that the States are firmly sold on the community care principle and are willing to assume the primary responsibility for carrying the program forward. A significant number of centers are already in place. Every State has at least one community mental health center—which has received Federal support—and, in others, such as Kentucky, Maine, and Montana, for example, more than three-quarters of the population live within the service areas of funded centers. Further, many States have adopted a community mental health orientation to service delivery. We note, for example, that in 35 or more States community mental health services acts which provide a State commitment for continuing support have been enacted or are pending.

In a few States, for example, Mississippi and Alabama, a significant portion of current State revenue-sharing funds have been dedicated to mental health improvements. In Baton Rouge, La., city-parish revenue sharing funds will be used to purchase a building to provide a full range of outpatient services as part of the Baton Rouge Community Mental Health Center. In addition, as the Secretary also said on March 29, "The success of the individual centers which do prove viable

should be an adequate incentive for other localities to undertake these services to its people." We believe that the current momentum behind the community mental health concept will be adequate not only to maintain existing but also to stimulate the establishment of new centers.

An additional aspect in insuring the fiscal stability of any center is its ability to maximize its utilization of medicare, medicaid, and other third-party health insurance programs. Federal initiatives and technical assistance are now aimed at helping community mental health centers makes maximum use of such resources in their planning for services. Regional offices and NIMH central office staff have been advising center directors on ways to arrange for basic benefit packages in public and private insurance programs so as to eliminate gaps in coverage for mental health services. In addition, center staff are being trained in cost accounting techniques and sound fiscal management, in contract negotiation, financial planning, and fiscal resource development. There has been extensive and focused assistance in the development of a data base.

But it is not enough to assure an adequate flow of funds to a project. The Department has been equally concerned with the way these funds are spent. The results of evaluation studies are being made available to center leaders to improve the delivery of services required by the residents of the catchment area. They have also been encouraged to conduct regular utilization reviews of each mental health service to insure high quality of care within reasonable cost boundaries.

CONCLUSION

In short, the Community Mental Health Centers program is not being terminated. What is being terminated are Federal grants for new community mental health centers. Sufficient funds have been requested to complete existing commitments. The administration is, however, continuing to support, with technical assistance, consultation, resource development, and the dissemination and diffusion of mental health knowledge, the future success of the program and will retain a strong leadership role in the stimulation, development, and strengthening of community-based mental health programs.

We will be pleased to try to answer any particular questions you may have.

Mr. ROGERS. Thank you, Dr. Zapp. Mr. Hastings.

Mr. HASTINGS. Thank you, Mr. Chairman. I will be brief, because it seems as though we have been over this ground before and probably will be again. Doesn't it seem that the real question at issue is whether or not the congressional intent was that these be demonstration projects only, as opposed to what the subcommittee feels—that is, it was not a demonstration program?

Dr. ZAPP. Mr. Hastings, I think that is the heart of the question before the committee and between the executive and congressional branch of the Government.

I would tend to focus some more on another issue. We have had disagreements on the legislative history before the committee. I agree with you any continued discussion is probably no more apt to bring agreement than when the Secretary was before the committee.

Mr. ROGERS. Did you say there was some disagreement on the legislative history?

Dr. ZAPP. I said: On the disagreements of the legislative history between the Department and the committee when the Secretary was here before.

Mr. ROGERS. It is in writing, and it is very clear. I am not sure I understand that statement. In fact, if you need it read to you, I can read it on page 9 of our own committee statement, where we say: "The long term goal of the community mental health program is the establishment of a network of comprehensive mental health services that will serve the total population of the United States"—total population, not 500 communities. "The overall response to the program, as reported to this committee, testifies as to the readiness of the Nation to institute a community system of mental health care.

This potential can be realized, however, only with an adequate base of resources for planning, initiating, and developing the quality of programs essential to assure the equitable provision of services to all communities.

I don't think there is any question about it. The Department may be stating how they want to proceed, but the legislative history is quite clear; and, as one of the authors of the act, I can confirm what is in writing; it is correct.

Dr. ZAPP. I will acknowledge what you read as part of the legislative history but would further state——

Mr. ROGERS. It can be confirmed in any other part of the legislative history.

Dr. ZAPP. I think the Secretary was drawing a further analogy to the fact that this committee, as well as other committees, continue to review certain programs and the fact there was an expiration date originally on the authority as well as continued expiration dates placed on the authority.

Mr. ROGERS. We review all legislation originating in this committee. That does not mean the program is not adopted—because we are reviewing it. We are reviewing it now because you don't seem to understand the intent of Congress. That is why we are reviewing it.

Dr. ZAPP. The point I was about to make to Mr. Hastings in more central than our agreement or disagreement on the legislative history—that is, the Federal involvement in the mental health centers at this time. The health strategy is as expressed in my statement. That is the appropriate Federal role.

We are saying: With changes made by Congress itself, as well as proposed by the executive branch, during that period of time, we have indicated a much stronger emphasis on individual assistance. In fact, most of the HEW budget goes out for payment of services as opposed to developing systems for delivery of services.

We feel at this time the Federal role should be one of adequately demonstrating new concepts and proving they are worthwhile and turning them over to State and local resources to operate. We have a responsibility and now are giving a commitment to improve mental health and to provide financial access to health services. We see this as the role of assistance to individuals.

Mr. ROGERS. Yes; I understand.

Dr. ZAPP. That was a different role than I think Congress assumed in 1963, prior to the passage of medicaid and medicare.

Mr. ROGERS. One can have all the money in the world, but, if there is no facility in the community, no doctors, no psychiatrists, it doesn't do any good, does it?

Dr. ZAPP. I understand, Mr. Chairman.

Mr. ROGERS. Excuse me; it is your time again, Mr. Hastings.

Mr. HEINZ. Mr. Chairman, should I indicate that nearly all of his 5 minutes has expired?

Mr. ROGERS. We have not yet invoked the 5-minute rule, Mr. Heinz, but I will remember that as you begin your questioning.

Mr. HEINZ. I just hope Mr. Hastings will be brief.

Mr. ROGERS. All right.

Mr. HEINZ. Let the record show this was accompanied by a wink.

Mr. ROGERS. All right.

Mr. HASTINGS. Is there any difficulty with the concept by the Department?

Dr. ZAPP. None at all.

Mr. HASTINGS. There is no need to get into facts or figures as to what it has accomplished in the communities?

Dr. ZAPP. No; we would find ourselves one of the strongest supporters.

Mr. HASTINGS. You make reference to national health insurance as shortly to be introduced which will contain some mode of delivery of service to mental health, and yet the pragmatics that we deal with indicate there will not be any passage this year by the Congress of any national health insurance.

I think you are probably aware that this committee won't have jurisdiction over the matter; the Ways and Means Committee does. Any argument saying national health insurance could supply some of the need to community health centers—that probably won't mean anything this year. I know the committee cannot say it is going anywhere, because Congress is not going to act. I have to remove that from my mind as an argument on this year's funding for health in community mental health centers since I am convinced we will have no national health insurance.

At the same time, I am aware the administration will not submit this year a special revenue-sharing health proposal which will provide funds for the continuation of this type of community mental health center. I am correct on that, I believe, from the testimony of the Secretary when he came before the subcommittee.

Dr. ZAPP. I think it highly unlikely we would get into health revenue sharing. The Secretary indicated we have it under review. We share with the community a certain sense of that under 314(d) funding that goes to the States. How far we will go with that is not yet decided by the Department.

Mr. HASTINGS. Certainly in the foreseeable future, this coming fiscal year, we cannot expect the States will receive any financial help from revenue sharing or benefits from the national health insurance?

Dr. ZAPP. That is correct. My comment on national health insurance is part of a long-range financial base. There has been an increase through third-party reimbursements, from the Federal sector, the States, and, in many cases, from insurance companies.

We are saying that it is our proposal and that this be further enhanced. When Congress passes national health insurance we will have a component. We are not proposing to withdraw any support or assistance made to the community health centers.

Mr. HASTINGS. Those in place?

Dr. ZAPP. That is right. We feel we should not get involved in any new starts, any 8-year commitments.

Mr. HASTINGS. If we believe in the concept of getting new starts, we don't cover anywhere near all of the country. I am referring back to the funding necessary to get them started. I have to rule out national health insurance, rule out special revenue sharing for health.

You mentioned 314(d). I understand the administration is asking for special earmarking on 314(d). Am I correct?

Dr. ZAPP. That is correct. There is no way—I think we have indicated that—of retrenching from community health. The State should have more flexibility and choice to set their priorities. We think, with some 35 States having or having pending before their State assemblies community health assistance acts indicates strong commitments from the States. We don't think it is something they will shy away from because the earmark is not there.

Mr. HASTINGS. I think that is true. My own State, the State of New York, already has a strong ongoing program. I know those legislatures don't move that quickly. My concern is that, without funding available for new starts, without the knowledge that all these States are, in fact, going to be able to establish programs—this is my interest in continuing this program as well as others for 1 year to give us and those States and communities the opportunity to find where they are going to find the money to make new starts.

I am not saying there should not be some consideration of the administration's position, but I know of no alternatives now; that is my problem. As of June 30, there is no more program. I don't know of the alternatives that will allow new starts to be made around the country.

I won't belabor the point; you know my position. We have discussed it many times. I think it is consistent with what I feel is the obligation of this committee and the Government that we provide those alternatives. I don't see them now, and that is my major interest and concern in extending for 1 year as those become more visible to us.

Thank you, Mr. Chairman. I yield back the balance of my time.

Mr. ROGERS. We will give you more time if you need it, Mr. Heinz.

Mr. HEINZ. Thank you, Mr. Chairman. Dr. Zapp, there has been a reported population decline in our State mental hospitals—a decrease in population of our State mental hospitals. Do you agree with this?

Dr. ZAPP. Yes; I have no disagreement with that at all.

Mr. HEINZ. Is there data to support this?

Dr. ZAPP. Yes.

[The following information was received for the record:]

DECLINE IN RESIDENT POPULATION OF STATE HOSPITALS, NUMBER AND PERCENT CHANGE IN INPATIENTS AT END OF YEAR, STATE AND COUNTY HOSPITALS: U.S., FISCAL YEARS 1967-71

Fiscal year	Total U.S. number of inpatients end of year	Period	Total U.S. percent change
1967	426,309		
1968	399,152	1967-68	−6.4
1969	369,969	1968-69	−c7.3
1970	338,938	1969-70	−8.4
1971	307,879	1970-71	−9.1
1972	275,995	1971-72	−10.4

The above table indicates a total reduction of 150,314 resident inpatients over the period 1967-1972. This is a 35 percent reduction overall.

Mr. HEINZ. Is there data that evaluates the effectiveness of the community mental health program?

Dr. ZAPP. Yes; I think perhaps Dr. Brown would be in a better position to explain the statistical correlation in having a community mental health program available where we previously had a high institutional level.

Mr. HEINZ. My third question: Is there additional data supporting the effectiveness of community mental health centers in dealing with the programs and competing with State mental hospitals?

Dr. ZAPP. Yes; the program has been in existence for some 10 years. On the actual operation, I think much of it is favorable, probably some unfavorable, as you would expect with a program this large in over 500 centers. We would be pleased to provide copies of that data.

Mr. HEINZ. I am sure that would be helpful to the committee.

[The following information was received for the record:]

CORRELATION BETWEEN STATE MENTAL HOSPITALS AND COMMUNITY MENTAL HEALTH CENTER PROGRAMS

There has been a steady and increasing reduction in State mental hospital resident populations over time. Over the 5 year period 1968–72, there has been a total reduction of more than 123,000 resident inpatients. In 1972, there were less than 276,000 resident inpatients in State and county mental hospitals, a decline of 31 percent since 1968. As an increasing number of community mental health centers have become operational, the rate of annual decline in resident patient populations has accelerated.

Mr. HEINZ. The complaint has been made that community mental health centers are not getting to the people who can least afford mental health care. Under the 1970 amendments to the enabling legislation, additional support for CMHC's in poverty areas was provided. Do you know if this additional support has been effective?

Dr. ZAPP. I will give an initial answer. We have funded 493 centers and 268 of them are located in poverty areas, and 225 in nonpoverty areas. We can say the majority have been established in poverty areas.

Mr. HEINZ. What percentage of all the patients—as opposed to the centers—the patients seen in these centers would be medically indigent?

Dr. ZAPP. I would refer to Dr. Brown.

Dr. BROWN. We have dramatic figures; those families having an income of under $5,000, of all the patients seen in 1971, 62 percent were under $5,000 family income. $5,000 to $15,000, 34 percent. We have tables that lay this out.

Mr. ROGERS. $5,000 to $15,000 was what percent?

Dr. BROWN. Thirty-four percent. Over $15,000, 3 percent.

Mr. HEINZ. Do you have a breakdown under $7,000?

Dr. BROWN. We would have to get that; I think we could get that; our tables are that detailed. We just put it for $5,000 and under. Actually, even $3,000 and under, which meets welfare standards—we have perhaps a third of our patients in that category.

Mr. ROGERS. I think it might be helpful to the committee to have a more elaborate breakdown; and, without objection, it will be made part of the record.

Dr. BROWN. Yes, sir.

[The following information was received for the record:]

Additions to Community Mental Health Centers by Family Income
United States, 1971

Family income:	*Percent distribution*
Under $2,500	42.2
$2,500 to $4,999	20.4
$5,000 to $7,499	17.8
$7,500 to $9,999	10.3
$10,000 to $14,999	6.3
$15,000 and over	3.0
Total	100.0

As may be noted, more than 80% of new additions to community mental health centers in 1971 had incomes below $7,500.

Dr. BROWN. We have studies that compare in-place centers with a comparable community to see what the percentage of patients coming to the State institution is.

Mr. ROGERS. That would be a great item to have. Give us a quick rundown and submit it for the record.

Dr. BROWN. Where a center has been operational 3 years or longer, the possibility of a person being a mental patient in that area is reduced by a third. We will submit figures on that.

[The following information was received for the record:]

STATISTICS BEARING ON CMHC PROGRAM OBJECTIVE: Decrease the inappropriate utilization of State hospitals

Years center has been in operation	Catchment area residents inpt. in State mental hospitals, 1971		Ratio of CA rate to U.S. rate (=1.51)	Admissions of CA residents to State mental hospitals, 1971		Ratio of CA rate to U.S. rate (=2.03)
	Number	Rate per 1,000 CA residents		Number	Rate per 1,000 CA residents	
All centers[1]	14,959	1.11	0.74	23,210	1.73	0.85
Under 1½ years	2,322	1.26	0.83	3,872	2.09	1.03
1½ to 3 years	4,119	1.14	0.75	6,619	1.84	0.91
3+ years	8,518	1.07	0.71	12,719	1.59	0.78

[1] Data are based on reports from 94 of the 294 operating centers in 1971.

Dr. BROWN. As we look at the decline in State institution population, which everybody has been familiar with for many years, it was 570,000 in 1957, approaching 600,000 when the drugs and new approaches came along, and about 500,000 when the community health effort got underway. The slope of the curve has been going down and the resident patient population is down to 275,000, a reduction by 50 percent. If you look at the actual changes from 1967 to 1968, 1968 to 1969, the percentage changes are dramatic.

There was a decrease of 6 percent from 1967 to 1968, 7 percent from 1968 to 1969, 8 percent from 1969 to 1970, 9 percent from 1970 to 1971, and 10 percent from 1971 to 1972, last year.

Mr. HEINZ. What you are saying is: As the programs become better established, as they become more effective and become better known in the community, in fact as we provide continuity for those programs, they do a better job.

Let me get back to the medically indigent people served. Do they pay any fee at all when they go to a mental health center?

Dr. BROWN. Many of the mental health centers, though not all, have a sliding fee arrangement. At the indigent level, I would say no fee is the rule. Many or some are supported by medicaid, welfare, or other funds.

Mr. HEINZ. To what extent are they supported by medicaid?

Dr. BROWN. We have figures on that. Again, looking at the 1969 figures and the 1971 figures gives us a trend line on medicaid and medicare which is helpful and illuminating. Medicaid in 1969 was a small 2 percent of the total funding in patient care and mental health centers. It has gone up to 5 percent in 1971. Medicare was 1 percent in 1969. It has gone up to 2 percent.

If there is any underserved group, it is in the aged population.

Mr. HEINZ. If, in fact, it is true that the vast majority of people served are poor—and I think we will see, when you get your figures in, that people under $7,000 probably come close to 80 percent of all the people served—I think what we are talking about here is a very small proportion of the cost for the poor—and, by "the poor," you could even apply a very strict definition—a small percent of those costs are being paid by medicare or medicaid. Medicaid, in particular, is of some concern to me.

To what do you attribute the failure of third-party payment structures, such as medicaid, to provide adequate reminbursement to mental health centers?

Dr. BROWN. There are several major reasons for the poor performance of medicaid in providing mental health coverage. There are two major sides of the coin in the medicaid programs which are the responsibility of the State. First, many States limit coverage for mental health, so we have a State prerogative for the extent of coverage of mental illness.

The second point would be that the centers often have no incentive to increase their medicaid collection. This is a deficiency on our part as well as theirs, but we have increased our efforts to encourage medicaid and other third-party payments.

Those are the two major reasons.

Mr. HEINZ. Is there any reasonable pruspect that medicaid will change substantially over the next several years in order to play a more important role in picking up these expenditures?

Dr. BROWN. I would like to defer to Dr. Zapp on that. The way I understand it, medicaid will become a component of perhaps a different and more comprehensive health scheme.

Dr. ZAPP. I don't see any pending proposals nor immediate legislative action. The authority is there, as it is a Federal-State program with the State option.

I think the latter of the two points Dr. Brown made is one we can't overlook in community health centers. That is, we have not been doing a good job, because there has not been the incentive on the part of centers to collect third-party reimbursement.

Mr. HEINZ. Do you think, since a number of community mental health centers each year, if you will, are maturing, and direct Federal support is being reduced—do you think at the end of the Federal support period, some percentage of our mental health centers will fold?

Dr. ZAPP. I would hope that the percentage would be low. I would be surprised, with this number, if there weren't a few centers that

would drop out. However, the congressional intent with an 8-year phaseout really gives them a long time. One reason for folding could be poor management, as an example.

There is a lot of community involvement in most centers, and there is time for them to make what changes have to be made. It is not a quick phaseout.

Dr. Brown may have information on specific ones. It is my understanding that most reaching the end of their period of support have good prospects for continuing their operations. They may have to change the scope. You have a lot of additional outreach and social services they have been able to perform because of heavy Federal dollars. They have to begin to concentrate on other dollars, and they may have to concentrate on the scope of their activities.

Mr. HEINZ. Let me ask a question that relates to something Dr. Brown referred to. That is simply this: Do you see that HEW has any responsibility to ultimately prepare and, in fact, encourage mental health centers for their eventual independence?

Dr. ZAPP. Yes, we feel a responsibility, and I think NIMH has had an aggressive program in technical assistance helping centers work on their programs. Dr. Brown may illuminate a little more. Yes, we feel we have a responsibility, and it is our understanding NIMH is aggressively carrying it out, not only here, but from our people in the regional offices, which are closer to the community level.

Mr. BROWN. Our first class of graduates is due up next year, those centers that will have finished 8 full years of support. Those with the 8 full years of support, approximately 75—40 have additional support, child support, drug and alcohol support, and 35 stand alone.

I don't expect any of them to fold. The reasons are first, if they have intrinsic worth, the community or the State or localities will come through. Second is we have had a very aggressive and helpful program in trying to prepare for third-party funds or other resources.

When centers stand alone, we are concerned there will be shifts in the types of services provided. Funds for those services that are really available in hospitals, as for example, inpatient care are not so easily available for some of those centers. We are concerned about that shift. It may not take place, but we are worried.

Mr. HEINZ. Very good. Mr. Chairman, I have many more questions but not at this time.

Mr. ROGERS. Mr. Kyros.

Mr. KYROS No questions at this time.

Mr. ROGERS. Mr. Hudnut.

Mr. HUDNUT. No questions.

Mr. ROGERS. Mr. Nelsen.

Mr. NELSEN. Thank you, Mr. Chairman. I am sorry I missed your testimony, Dr. Zapp.

In Minnesota, now that we have these centers, the population of the State mental hospitals has gone down so tremendously, and the reason is that, in instances where help was needed, it was provided and a cure effected locally and it has been a great program.

A few years back, I remember in the original legislation we did not provide staffing and we finally found that staffing was one of our major problems. Are you of the opinion that the staffing burden can be met? I notice, in your last paragraph, you state: "In short, the community

mental health centers program is not being terminated. What is being terminated are Federal grants for new community mental health centers. Sufficient funds have been requested to complete existing commitments. The administration is, however, continuing to support with technical assistance, consultation, resource development," and so forth.

Now, do you have any feeling in the area of staffing, looking to the future, that there will be assistance, or do you plan to terminate that?

Dr. ZAPP. The program has an 8-year phaseout. As Dr. Brown mentioned, the graduates are just now coming into being, those with 8 years' support completed. We don't see them folding because of the lack of Federal support. They have found a variety of resources to pick up. Without staffing assistance at the end of the 8 years, I think they will be able to continue.

Because of changes inside and outside the Federal Government, the range of services they provide may switch to be more parallel with the reimbursement mechanisms available to them at that time. NIMH will watch very carefully for this. We don't think they will fold. We think they will continue.

Mr. NELSEN. As I remember it, in Minnesota we started 11 different centers. Hasn't there been a tendency to have a lesser number and yet a better unit and take care of a wider area instead of having so many of them? Is that a trend now?

Dr. BROWN. Minnesota was a leader in starting with the outreach community approach, and their centers had outpatients and consultation services and then expanded to day care.

Mr. NELSEN. I was there; I know.

Dr. BROWN. They helped us in our pre-1963 thinking; during the late fifties and early sixties they were the leaders. As it has gone forward, there have been other services.

Mr. NELSEN. No further questions.

Mr. ROGERS. We would like to have answers to the questions submitted by Mr. Symington.

[See p. 29.]

Mr. ROGERS. I think it is clear the Department feels it has been a successful program.

Dr. ZAPP. Yes, I think that is a correct statement.

Mr. ROGERS. The Secretary indicated that.

What is the need, the national need, in mental health? Is there still a problem? Do we have people that have mental illness in the country, or is it about over?

Dr. ZAPP. I would think we still have and will always have people in the country having a need for mental health services. We think, as Dr. Brown mentioned a minute ago, the potential need to have people for inpatient treatment has been shown to be decreasing where there is service at the community level.

Mr. ROGERS. We can avoid inpatient treatment if we can give them outpatient treatment rapidly in their own community. Is this true?

Dr. ZAPP. That is correct.

Mr. ROGERS. In areas not having community mental health centers, what happens? Do they have more inpatient demand? What happens?

Dr. ZAPP. I would say several things would happen. One, yes, there would be more inpatient demand. I would tend to think—Dr. Brown can speak better to this—there is also becoming increasing sophistica-

tion and awareness on the part of the individual professionals in those areas where the community health center doesn't exist. I think they would tend to try to treat the people on an outpatient basis. That is the creditable concept that appears to be needed.

Mr. ROGERS. You think it is a good idea to continue to build community mental health centers, but you want them to do it?

Dr. ZAPP. We feel it is no longer necessary or appropriate for the Federal Government to continue to start community mental health centers.

Mr. ROGERS. Although the need exists in the community for the mental health center?

Dr. ZAPP. Yes, as it would for many other health services. We don't think the Federal Government can do everything in every area, and we are trying to make selected use of the scarce resources we have.

Mr. ROGERS. Is mental health a major national problem?

Dr. ZAPP. Yes, as many others are.

Mr. ROGERS. And we know we can do something about it?

Dr. ZAPP. Yes.

Mr. ROGERS. But you are saying, "Let's not do it; let the community do it?"

Dr. ZAPP. To have something done about it, is no longer necessary for the Federal Government to bear the same burden it has in the past. We think we have done great things, along with the Congress, by community health services' proving themselves and providing health services. The growth, although it may be less even without all the Federal dollars coming in for construction and staffing, will continue. We do have other areas that have equal needs.

Mr. ROGERS. Let me ask you: What study has been made to determine that the local communities will assume the burden and that the local communities will build these? Have you a study for a basis?

Dr. ZAPP. I think Dr. Brown can answer that. There have been community health centers established without Federal assistance.

Mr. ROGERS. I am sure there are some, but the vast majority were encouraged by the seed money from the Federal Government.

Dr. ZAPP. Yes, but that is not to say some have not.

Mr. ROGERS. I understand a few may. What I am saying is: With a major national problem, there is no study that shows all of these communities will build them. How many will? Have you made a study of that?

Dr. ZAPP. I am unaware of anything that would show statistically what will happen in each of the catchment areas where there is not Federal assistance.

Mr. ROGERS. Do you know what mental health programs have been approved but unfunded with staffing grants, have built their own facility now on the promise the Federal Government would give a staffing grant? Have you got those figures for us?

Dr. ZAPP. Yes.

Mr. ROGERS. How many have been approved but unfunded in their staffing grants?

Dr. BROWN. We have 78 community mental health centers' applications for $39 million that have been approved but unfunded, Mr. Chairman.

Mr. ROGERS. Is there a reason why they are unfunded?

Dr. ZAPP. The same reason that exists in almost every program—that you continue to have more applicants than the Federal Government has funds to award.

Mr. ROGERS. Have any funds been withheld that have been appropriated?

Dr. ZAPP. In the Public Health Act, I am unaware of any funds that have been withheld.

Mr. ROGERS. Even in the Hill-Burton program?

Dr. ZAPP. I am unaware of any. I think the report Secretary Weinberger made to the Senate Finance Committee was that there were no public health funds withheld. There may be funds that were authorized, but impoundment in not allowing the outlay of appropriated funds is a separate consideration.

Mr. ROGERS. I won't get into that, but my information varies greatly.

So there are 78 unfunded centers built with local effort?

Dr. BROWN. Most of those—of the 78 grants, Mr. Chairman approximately 57 are staffing and not construction.

Mr. ROGERS. I understood that was where they may have gotten their building together or worked out places where they could have provided services. Is that correct?

Dr. BROWN. I don't have that figure at my fingertips.

Mr. ROGERS. Could you get that for us, please—how many received construction grants that are approved but no staffing? Are there any?

Dr. BROWN. Yes.

Dr. ZAPP. I would assume in the 78, you would have a mix.

Dr. BROWN. Of the total Federal support, 130 centers received construction grants but no staffing grants, unless you are still asking about the universe of approved unfunded rather than those unfunded that have not received staffing grants.

Mr. ROGERS. It may be well to break both those figures down. Could you give those to us?

Dr. BROWN. I will be glad to provide them.

[The following information was received for the record:]

CONSTRUCTION GRANTS WITHOUT STAFFING GRANTS

As of July 1, 1972, 130 of the 493 funded community mental health centers had received construction support only, without staffing grant support. However, receipt of a construction grant commits the grantee to the development of a community mental health center program regardless of whether subsequent staffing grant support is requested, or available.

Mr. ROGERS. What has been our contribution, the seed money? What would be the overall cost?

Dr. ZAPP. That we have contributed?

Mr. ROGERS. Yes.

Dr. ZAPP. I think, on the staffing funds through 1972, some $411 million.

Mr. ROGERS. What has been the local and State contribution?

Dr. ZAPP. In excess of that; I think the staffing grants are around 27 percent of the operational support for the community mental health centers. Those exact figures would change each year as the Federal match goes down. Dr. Brown may have that.

Mr. ROGERS. What would you say about the average contribution?

Dr. BROWN. I think one of the ways to put it is that each Federal dollar has produced $2 of non-Federal support. Of the $400 million provided in the history of the program, approximately $700 million to $800 million of non-Federal funds has been provided by States, localities, private fees, and the like.

Mr. ROGERS. What about for construction?

Dr. BROWN. That is closer to 50–50 if you look at the total.

Mr. ROGERS. Which has been the old Hill-Burton pattern.

Dr. ZAPP. About $253 million to date have been put in construction—the Federal share.

Mr. ROGERS. What do you think of this statement, Dr. Zapp: "The selective nature of these programs is inequitable to the Nation as a whole because relatively few communities receive Federal funds"?

Dr. ZAPP. Do I give validity to the equity argument?

Mr. ROGERS. Yes.

Dr. ZAPP. I think one point is: Do they give a rationale to the program? The other is: Is there inequity? Yes, of course. I don't think the equity argument is valid. I think there can be disagreement whether this equity is a valid Federal purpose and should be considered. Of course it is inequitable to have this much money going to some areas and not others.

Mr. ROGERS. It is all right to help 500, but here are others ready to go but we are going to chop it off. Is that equitable? That was the argument used by Roy Ash in his justification for stopping this program.

Dr. ZAPP. I think it is valid.

Mr. ROGERS. You really do even though we have acted on 500?

Dr. ZAPP. Yes, even though you acted on 500—if you take the administration's suggestion as to what the Federal involvement should be, starting up and then relying on State and local support to keep them going.

Mr. ROGERS. It is helping to get the local community started when you give them only 24 percent. Don't you think that is a pretty good reaction from the States—to come in with 70-some-odd percent? What do you want them to do—100 percent? Do you think they should do 100 percent?

Dr. ZAPP. We think that is an excellent response from the States.

Mr. ROGERS. It is an amazing response.

Dr. ZAPP. It is because of that we have confidence that community mental health support will not stop.

Mr. ROGERS. But you have not made a study; this is simply what you hope would happen?

Dr. ZAPP. There is information we can provide for the record where community mental health centers started without Federal assistance.

Mr. ROGERS. Is that the same percent you expect to continue?

Dr. ZAPP. The support of Federal dollars excludes local reaction sometimes. In many cases, it works in reverse. The fact that States know they are eligible for Federal dollars could lead to resistance in State legislatures. If they hold out they might get a 50-percent construction grant and 8 years' support on staffing.

Mr. ROGERS. It encourages them to do something, and they have responded.

Dr. ZAPP. They responded to the Federal match. The question is, Without new Federal support and with the new concept of States' giving assistance, what will they do? None of us know. We think strongly that even though the growth may be lessened—which I addressed to Mr. Hastings and Mr. Heinz a minute ago—we think the growth will still continue.

Mr. ROGERS. I understand this is what you think. What I am saying: We don't think that is necessarily true, and we don't think it will happen. You have no studies to show us. We do have a record of what has happened with a little Federal money properly invested.

Now, I know another administrative statement was quoted in the press as saying that the program is inequitable because those served by the federally funded centers receive better care than the rest of the Nation. Do you agree with that?

Dr. ZAPP. I think this would go back to the first half of my equity argument.

Mr. ROGERS. That was Mr. Ehrlichman. Did he have any input in the decision as to whether this program continues or not?

Dr. ZAPP. I can state he has not been on my call sheet, Mr. Chairman. I don't——

Mr. ROGERS. Yes, but did he call you? I am not talking about the sheet now. I wasn't thinking of his calling you but I am thinking of his input into the decisionmaking. Did either Mr. Haldeman or Mr. Ehrlichman provide any input? I am concerned when I read statements in the press that "We are going to cut out these programs because those people, where there has been Federal help in a center, are getting better care than the rest of the Nation, so we will cut it off."

That is the most absurd statement I have ever heard. If that is the reasoning—and it obviously is—for cutting off this program, then the Congress will have to take action.

Dr. ZAPP. I would again restate: The equity argument is only a small part. It is a part, and you can't deny the inequitable disposition of Federal dollars——

Mr. ROGERS. The way to stop it is to stop trying to handle equity and chop off the people relying on the program who have done their work to try to get the program to improve their community's health so their community will get the help the 500 have got.

Now, you say the way to be equitable is to chop it all off?

Dr. ZAPP. No; we are saying we think the Federal role in this particular case is one which has been proven.

Mr. ROGERS. "And it is successful, so stop it"?

Dr. ZAPP. The community mental health concept has been proven, statistically and otherwise.

Mr. ROGERS. "So don't do it any more; don't help people any more"?

Dr. ZAPP. No, Mr. Chairman.

Mr. ROGERS. That is what you are saying—"We don't want to start new ones."

Dr. ZAPP. I am not saying that.

Mr. ROGERS. You say: Stop the program. And yet you have not done any study.

Dr. ZAPP. There are ways to help people with assistance.

Mr. ROGERS. Let us not pursue that. Let me ask you this: Has any study at all been done, area by area, of what will happen to those who

have submitted their applications for grants? Do we know whether it is going to delay them a year, 2 years, 3 years? Is it going to stop community mental health services from being given to those communities? Will it be like in Watts, where, I understand, for 5 years they have been raising money to try to get their community mental health center? Now they are not going to be able to get help. What is going to happen? Has any study been made?

Dr. ZAPP. I will refer to Dr. Brown. I would state I would not like the record to show we don't feel the centers will not develop.

Mr. ROGERS. But you have not done a study. You say you "feel." This is what concerns me about all the attitudes. I have not seen any study where you have gone to the people and they say, "Yes, we can do it, we will do it, this is what we are going to do."

This may bring these people to a complete halt—to precipitously cut this 130 off, where they have relied on the word of the Federal Government in the laws of this land. It is a shocking example of deceit.

Dr. ZAPP. I think the 130 may be a distortion. I would like Dr. Brown to amplify on that. There are 130 that have received construction assistance; they may not need staffing assistance. If we have only 78 approved but unfunded grant applications totally——

Mr. ROGERS. That is for staffing only?

Dr. ZAPP. Is that for staffing or construction?

Dr. BROWN. We have none for construction.

We are carefully working with those 78 to do everything we can to make sure they get going——

Mr. ROGERS. I am sure you are, but it doesn't do much good to work with them, talk to them, when you haven't got any help for them.

Mr. Nelsen.

Mr. NELSEN. Dr. Zapp, back home in Minnesota when we started our program under Governor Youngdahl, we received no Federal moneys at that time, is that true?

Dr. ZAPP. Not the type of Federal assistance that has been available since the 1963 passage.

Mr. NELSEN. Our State found that, by using this process, the inpatient facilities population diminished; it was a dollar saving to the taxpayers of our State because we did use this concept. We found that out by experience.

Now, then, the question I also want to pursue is that in the Hill-Burton approach, the various communities are beginning to realize that to wait their turn year after year because we don't appropriate enough dollars to build hospitals in every town in the United States of America is useless. They have bought the concept of a guaranteed-type loan thing so they can move faster. It has its advantages.

I know the Federal Government doesn't have the dollars to do the total job, and I am hoping the experience we had in Minnesota and the experience gained from what you have already done will stimulate communities to do more themselves. If you stand around and wait too long, maybe you deter the program from advancing by local initiative rather than stimulating it from the top level.

I don't exactly endorse the idea that, just because of a lack of dollars from this level, the administration is necessarily opposed to the program.

You did indicate, in your testimony, in areas where something was started, that you intend to stay with them; you are not just arbitrarily cutting them off.

Now, then, I know that at the national level, the total dollars available for all programs are inadequate when you take the needs of the country and the dollar income and we find, to our embarrassment, that we have $24.7 billion interest payment a year, we pay $2 billion a month, because we go on a deficit spending basis and throw dollars at every problem to a point that we now are spending $24.7 billion a year for interest on borrowed money.

So I don't quarrel with an attitude in your department of trying to motivate communities back home. At the same time, I think that we need to take into account the total dollars available to us.

As I pointed out again and again, our medical schools are in need of help, too, and we don't have the total dollars I think we need.

So our good chairman and I sort of go in tandem; and I think we demonstrated, Paul, that, working together, we have tried to come up with some of the best answers for the best interests of the country.

I just want to say, Dr. Zapp, I want to compliment you on your diligence in your job and your attendance before the committee time after time to help us.

I perhaps was interested in these mental health centers long before most of the members of this committee, and I well remember the first appropriations out of our Finance Committee; the Governor wanted $80,000; I wound up getting $60,000, and he wasn't too happy.

We have a good program in Minnesota. It was a good investment. The population at St. Peter is way down. I don't think the State should forget the motivation at home is a part of the total package. I am sure Chairman Rogers would agree with that.

We will do our best to work this whole program out. I thank you for your appearance.

Mr. ROGERS. I am sure we will work it out.

I might say I was somewhat startled that you asked for $600 million in this budget this year over and above what will be expended for the obligation over an 8-year staffing time. All you needed to ask for was what was needed this year and then ask for it each year.

Mr. NELSEN. I didn't ask for it.

Mr. ROGERS. No; I just wanted you to know the administration put in about $500 million over and above what would be needed for staffing, which should ease the problem we have. It will help us both because we can reallocate some of that budget.

Mr. NELSEN. Off the record.

[Discussion off the record.]

Mr. ROGERS. On the record. We will work things out.

I am concerned where this program follows the philosophy of what they are telling us. They want to initiate local efforts, but we have had such a successful program. And now, to cut it off and say they think it will go, concerns me.

I was glad to see, in Dr. Zapp's statement, where he said: "A more limited Federal role and increased reliance on the capabilities of local public and private sectors are, however, indicated in certain other situations, such as the demonstration of new facilities or services or

startup funding for their establishment." That is what this program really is, so it is consistent even with your statement.

Dr. ZAPP. As long as one bears in mind the preface to that statement; that does not mean a commitment because of having proven the concept.

Mr. ROGERS. I understand there is no commitment even in the Federal Government. We provide the law but you won't provide money for the medical schools. Yet we know the need for doctors and nurses is well documented. That is why I supported Mr. Nelsen in trying to get support for his medical school—they need it.

Mr. Kyros.

Mr. KYROS. Will revenue-sharing funds be used—is that what you are imagining—in some States and communities to support these programs?

Dr. ZAPP. I would imagine. As I said earlier, there are some 35 States that have mental health assistance authority. It is within the authority of the State whether they want to use certain earmarked funds of revenue sharing. We would consider general revenue sharing is the answer to continued support for mental health centers. We think, once a concept is proven, it depends on the priority the individual States and localities place on it.

Mr. KYROS. As yet, we don't have any specific data that would indicate whether any city or State actually did use revenue-sharing funds to support these centers. Is that correct?

Dr. ZAPP. Yes; I had things in my statement that indicated some examples we know of. And, in some cases, when it flows into the treasury, as they begin the reallocation process; it may be impossible to track funds freed up for mental health activities because general revenue-sharing funds may be used for something else.

It would take a master audit in each of the States, once revenue sharing is in there, to show what funds are not used for that purpose and, therefore, freed up for something else.

Mr. KYROS. Another thing concerning me is: If, indeed, the community mental health centers serve economically poorer people, they could never become self-supporting, could they?

Dr. ZAPP. Yes, the large issue here is financial access for mental health services into the system. Again, depending on its priority, the State can include it in the medicaid program, and the Federal Government would match in each case. It is not the Federal initiative: it is the State's. Once the State allows those services, the Federal Government has no choice but to match.

I think this goes back to the center of the discussion that occurred between Mr. Nelsen and Mr. Rogers a few minutes ago about the health expenditures in the Department. They continue to go up; they have doubled in the 4 years I have been there.

The vast majority of those are uncontrollable, such as medicaid and medicare. In medicaid, the States are making the choice and can make the choice in mental health. There is a $3½ million increase in HEW next year. We have to come up with some choiees that are difficult for us and very difficult for Congress if they should choose to go with us.

Mr. KYROS. How many States have medicaid payments for mental health centers? Do we know?

Dr. ZAPP. I would refer to Dr. Brown or Mr. Feldman.

Dr. BROWN. Thirty-five, and they vary in what they cover. Some limit to just the inpatient services and only a handful have any outpatient coverage under medicaid.

Mr. KYROS. Some units attached to hospitals train psychiatrists, who do their internship there. We certainly need an input of psychiatrists into the medical system. If these mental health centers, then, are valuable training grounds, don't they have further value beyond serving patients?

Dr. ZAPP. I am sure they do. In every State in the country they are valuable as a part of the training experience for psychiatrists and other levels of mental health workers, professional and nonprofessional.

Mr. KYROS. Thank you.

Mr. ROGERS. Mr. Hudnut.

Mr. HUDNUT. Thank you, Mr. Chairman. I apologize for being late and not having my thoughts collected when you called on me before.

I would like to ask consent to insert in the record at this point a resolution forwarded to me from the State of Indiana on this point.

Mr. ROGERS. Without objection, it will be so done.

This is from the State of Indiana?

Mr. HUDNUT. The Senate of the State of Indiana.

[The resolution referred to follows:]

RESOLUTION OF THE SENATE OF THE INDIANA GENERAL ASSEMBLY

A senate concurrent resolution memorializing Congress to continue its support of the community comprehensive mental health centers program in order that Indiana's network of thirty-two community comprehensive mental health centers may be completed.

Whereas, In 1955 President Dwight David Eisenhower appointed the Joint Commission on Mental Illness and Health to study the problems of the nation's mentally ill; and

Whereas, The Joint Commission of Mental Illness and Health in its report to the President in 1961 recommended, among other things, the creation of community comprehensive mental health centers to provide treatment facilities for this nation's mentally ill in close-to-home treatment facilities; and

Whereas, In 1963 Congress passed the Community Mental Health Centers Act implementing the Joint Commission of Mental Illness and Health report and authorized federal dollars to assist the several states in providing its network of community comprehensive mental health centers; and

Whereas, Congress committed itself to becoming a full partner with the several states and local communities in the initial construction cost and staffing cost; and

Whereas, The Indiana General Assembly and the several counties of this state enacted legislation and provided the state's and local government share to create a network of thirty-two community comprehensive mental health centers for the citizens of the state of Indiana; and

Whereas, Ten centers are presently in operation in Indiana, five more will be operational within the next two-year period and the remaining seventeen centers will be operational by 1980; and

Whereas, The state of Indiana and local county governments have kept their pledge to the mentally ill of this state by enacting the necessary legislation and providing funds to complete the network of thirty-two community comprehensive mental health centers: Therefore be it

Resolved by the Senate of the General Assembly of the State of Indiana, the House of Representatives concurring:

SECTION 1. That the General Assembly hereby memorializes the Indiana Congressional delegation, the Federal administration and the Congress to renew the Community Mental Health Centers Act to permit the continuation and completion of the plan to provide community comprehensive mental health centers for all this nation's mentally ill and to authorize and appropriate the federal funds necessary to keep the national commitment as a full partner in combating mental illness.

SEC. 2. The Secretary of the Senate is hereby directed to forward copies of this resolution to the President and Vice President of the United States, to the Speaker of the House of Representatives of the Congress of the United States, and to all the members of Congress from the state of Indiana.

Adopted by Voice Vote this 13th of April, 1973.

JOSEPH W. HARRISON
State Senator.
BETH VAN VORST GREENE
Secretary of the Senate.

Mr. HUDNUT. I appreciate your statement. As you know, we are wrestling with the problem of funding the necessary programs and, at the same time, staying within the necessary budget limitations that fiscal responsibility would impose on us.

I have real problems with this facet of the overall tension that we are finding ourselves in, because it seems to me that the logic of the case is on the side of continuing rather than terminating the community mental health center program insofar as demonstration projects are concerned and getting these off the ground.

The HEW has identified almost 1,500 catchment areas, as I understand it, throughout the country, and we have only some 500 centers going right now. Mental illness is a problem in America. I don't know how many people are touched directly or indirectly by it—maybe 1 out of 10.

I think, on the basis of the history of the community mental health program today, there is a discernible correlation between the establishment of these centers, and a reduction of the State hospitals' censuses. Two examples: In the State of California last year in San Francisco, not one patient was admitted to a State mental hospital from that area. The California total State mental hospital census is, 4,500, which makes it the lowest of the major industrial States; and it is not just coincidental, in my opinion, that California began extensive development of community mental health centers about 15 years ago.

I am sure you recognize the validity of the program. But why should we cut it off when it seems successful? Example No. 2: In my State of Indiana, when I was a representative of the State Mental Association in Indianapolis, the census there was about 2,100 and, at that time, we got going on a community health center, and the population of the State hospitals is now down to 900. I think there is a correlation.

It seems to me the logic of the whole program would be that, if these experiences that I have cited from California and Indiana were duplicated throughout the country and if Federal funding for new centers were to be continuously made available, we would be on the right track and, in the long run, be serving the health interests of the country.

I think we are chasing a myth when we say, "If we reduce the Federal role, we will be giving the incentive to the States." My own State of Indiana, it seems to me, leads to the opposite conclusion. This resolution was forwarded from the State of Indiana to the Congress, memorializing us about the community mental health centers. Then States senators indicate there are other centers that might be completed but they can't do it without this funding. They have only seven or eight that are going now.

Just this year, for the fifth or sixth time in a row, the State of Indiana voted down a 2-cent tax on cigarettes to help with the mental health program—or 1½ cents or whatever.

I would question whether it is accurate to say that, as we diminish the Federal role, the State will receive an incentive. I think it will be a disincentive.

Dr. ZAPP. I would have to look at Indiana. I would say their choice was not that they couldn't; they would choose not to. I can hardly believe a State, in a situation like this, would not choose to have a continued program without Federal assistance. I am saying the proposed switch, from the administration's standpoint, to assistance to individuals, does not mean that the States won't meet the responsibility. We think they will. We think it would be, you might say, very poor poker, from their standpoint, at a time when it is pending before Congress, to say, "Well, if the Federal Government doesn't complete our network of 32 centers, we will do it ourselves." I would anticipate this is the type of thing we would get from the States.

But we firmly believe the validity of the concept has been proven. The basis for the community support, the fact your program got involved and started 15 years ago and not 8 years ago, when the first grants were made under the act, indicates there is a residual feeling in the State.

Mr. HUDNUT. Our program started 8 years ago. I mentioned that California, according to the information I have, started about 15 years ago.

It is a question of value judgment. We are involved in this continually in the committee. There is evidence there is a difference in the evaluations and judgments made. I am not trying to set up an adversary relationship, especially between the Republicans, the minority, and you, but I feel the way you have evaluated this program, if it is successful, we would save money if we spent some money on this program.

Dr. ZAPP. We feel the money will be expended perhaps at a more uneven rate. I would point out Congress itself has switched the outlay process within HEW heavier and heavier to the individual in all appropriations.

Mr. HUDNUT. I am a freshman and don't have the vast accumulated experience represented to my right down the table here, but do you think Congress, when it set up the act back 10 years ago, made any kind of a moral commitment to the mental health program in the United States or to the mentally ill people to proceed with this to a successful conclusion rather than to go about one-third of the way and leaves two-thirds of it undone?

It seems to me the Congress, in setting this up originally in 1963 and then amending the act several times since then, while it was intended originally that such assistance be limited inscope and brief in duration, nevertheless it was intended we do the job, move from one center that was on its feet, move to another catchment area and start there, until we worked our way through.

Dr. ZAPP. Between that time and now, Congress has done a number of other things—Medicaid, Medicare, and proposed national health insurance. There is a changed outlay of funds into assistance to individ-

nals. Congress has reevaluated and changed its position along the way or placed heavier emphasis. We are saying there are only certain funds available.

Mr. ROGERS. Except for this: You have put in $600 million more than you are going to spend for 8 years.

Dr. ZAPP. I am pleased you brought that up. I was afraid the record would show that we were proposing an outlay. That is not the case. We are saying: While the authority is available, we are proposing it expire June 30, this year. We want to request all the funds to meet the commitments for the next 8 years.

Mr. ROGERS. Do you do that in other programs? The Defense Department doesn't do that; they don't get funds for 8 years.

Dr. ZAPP. Mr. Chairman, the Department of Defense may not have the type of legislative authority we have.

Mr. ROGERS. Nor does HEW.

Dr. ZAPP. For the first time, I would hope, refreshingly, the executive branch and the congressional branch will join us in some of these and begin to evaluate the continuation of programs. There has not been a good legislative history across the board of looking at programs and saying, "Maybe we should see if our Federal program is completed; maybe we should shift emphasis."

Mr. ROGERS. We are looking at this. We are saying: You won't give us any evidence of what led to the judgment you made. You say, "We think." We are asking for your evidence and might agree with you, but you don't give us any evidence.

Dr. ZAPP. There is evidence available based on what has occurred in the field.

Mr. ROGERS. That is what the committee is judging on.

Dr. ZAPP. We would be pleased to provide that in detail for the committee. We are talking prospectively of what would happen. That would take every assemblyman and senator——

Mr. ROGERS. You would have to go to those 78 or the others starting out and say, "How will you proceed? How will you get your money?" It is simple—a few telephone calls.

Dr. ZAPP [continuing]. I think it is more complex.

Mr. ROGERS. Even that would be helpful to the committee.

Dr. Roy.

Mr. ROY. I keep hearing you make two diametrically opposite arguments. You stated to Mr. Hudnut that it is the Congress itself which developed open-ended assistance to the individual. You know and I know that this has a great deal to do with the $3.5 million increase in HEW's budget——

Dr. ZAPP. It is more than——

Mr. ROY [continuing]. Let me finish. This is the uncontrollables.

Dr. ZAPP. That is right.

Mr. ROY. Then you say that this great administration has adopted the wonderful policy of giving increased assistance to individuals so they will have greater access to the system. But if the Congress does that, you say that we destroy the system. I understand what you say, but I don't understand your reasoning.

Dr. ZAPP. I would like to respond to that. I am pleased with your recognition as indicated by your prefix to the administration.

We are saying: It is no longer an appropriate Federal role to continue developing the system. We are meeting our commitments and that is why we have asked for the money in 1974.

Mr. ROGERS. You have already approved several applications. You said they are right, they qualify and they are legal. Are there 78, or 130?

Dr. ZAPP. We have 78 approved but unfunded applications; there are 130 centers with construction grants but not staffing.

Mr. ROY. The argument is: "We have a number of uncontrollable programs, the Congress played a role in creating these uncontrollables, and we will, and should have, more uncontrollables because the major priority is to give assistance to the individual so they will have greater access to the health care?"

Dr. ZAPP. I am saying this is a trend both the executive branch and legislative branch are proceeding on. This does not eliminate the role we think is important for the Federal Government.

Mr. ROY. I fully agree we have to remove cost as a barrier to access to health care. But as we do this, we are going to have to have a system of health care that can provide health services efficiently.

I would suggest to you that comprehensive mental health centers are a part of this system. Yet you come in and say, "Let's tear down the system." I understand why you do that. You do it because of the tremendous pressure of costs. Under that pressure, you are making pennywise and pound-foolish decisions one after the other. This is what troubles me.

Dr. ZAPP. I would take exception to "tearing down the system." "To tear down" would indicate we are withdrawing support from something we started. All the community mental health centers given assistance, whether in the first years or the last——

Mr. ROY. If you don't like it that way, let us say: "the failure to build a system."

Dr. ZAPP. The failure to initiate new components of the system on a Federal level.

Mr. ROY. We are going to have a greater need for this system next year and the year following than any time before, is that correct?

Dr. ZAPP. I would think the need for the system was greatest when it started. The need for the system to continue to develop is something we would agree with. We disagree, with the limited resources the Federal Government has, to have its involvement for staffing and construction as it had previously.

Mr. ROY. Will national health insurance result in an increased burden on the system?

Dr. ZAPP. It will result in an increased financial outlay. I think ultimately it will be an increased burden.

Mr. ROY. But you say, "Let's not build the system; let's discontinue building the system," or "Let's have somebody we don't know"—as Chairman Rogers pointed out so well—"Let's have somebody out there, some vague group, locally or in the State, take up the responsibility, which we previously assumed, to build the system. Why? Because we think they will."

Dr. ZAPP. We think they will.

Mr. ROY. You may not like my language, but let's not skip around

the point. You don't know who will do it or whether it is going to be done?

Dr. ZAPP. We can't give a commitment as to what will happen in each State. We can give some information, and I offered to provide for the committee——

Mr. ROY. But the past experience: Has it been done?

Dr. ZAPP. I offered to provide that in detail for the record. We think local and State assistance and private resources assistance has been major and has aided the centers. We think 35 States have legislatively moved in this area.

Mr. HEINZ. Would you yield?

Mr. ROY. Yes.

Mr. HEINZ. The gentleman is pursuing a very important point. It is my hope the Congress will have a debate and a bill passed and signed in national health insurance one of these days. Whether it is in this Congress or another Congress, I certainly can't predict, but it would be a shame if, in that national health insurance legislation, the argument was made that we would have to cut out coverage of mental health because there was inadequate mental health care delivery systems available to supply it.

I think the debate we are having here with you goes far beyond the dollars and cents. It goes to the future and the kind of national health insurance that we are going to have in this country at some future date. Hopefully, that future date is not too far away.

I thank you gentlemen for yielding.

Mr. ROY. Thank you for your remarks.

Just for the record, so I don't deceive myself by finding out I know something you don't know, can you give us the approximate total expenditures for health care in this country, say 10 or 12 years ago, versus what they are now? Pick your year—1960, 1965, versus 1972.

Dr. ZAPP. We are in the $80 billions now, and I suppose 10 years ago we were probably half of that. We are up over 7 percent of the gross national product; we increase approximately 1 percent of the GNP for health care each year.

Mr. ROY. One figure is that we spent 25.9—let us say $26 billion in the 1960's; last year, as you said, it was in the 80's. That is a threefold increase. Last year increased how much from the previous year?

Dr. ZAPP. The expenditures?

Mr. ROY. Yes.

Dr. ZAPP. Roughly, an $8 billion increase in health care in the country.

Mr. ROY. It amounted to 10.8 percent; is that compatible with your information?

Dr. ZAPP. Yes.

Mr. ROY. Why do we have these increased expenditures on health care?

Dr. ZAPP. For a variety of reasons, certainly one of which we are both concerned about; that is, the inflationary cycle that has occurred in health care. If we take the previous time in the 1960's, when per capita expenditures went from——

Mr. ROY. Last year, we had phase II which was somewhat successful in the general economy in the controlling of inflation, and yet we had ever a 10-percent increase in health services?

Dr. ZAPP. If you would permit me to develop this, in the 1960's, when you started out with a per capita expense of $124 per individual, by the end of the 1960's it was $300. Sixty percent was inflation, and only 40 percent was increased quality or quantity of health care delivered. That was so much above the CPI or any other index that existed.

What we have found now, phase II and the fact we selected the health industry, which should have phase I or II controls, is: They begin to retard this growth to something closer but not approximating the growth of the inflation in the balance of the economy.

Nobody would make a case the inflationary base has been held stable, but the rate of increase has been retarded. It is the type of thing that is very long range. It has to do with the unoccupied hospital beds in the country and other variations. A few measurable things, such as physician fees, that are easy to control—those areas have been positive.

The other area causing the great increase besides inflation is the Federal programs, the employer-employee negotiated programs that continue to give benefits to the balance of the family as opposed to starting out just for the employee; all have a cumulative effect. There are more facilities available, an increased awareness by the individual of what preventive services mean; hopefully, more people see their doctors before accidents or illnesses.

Mr. ROY. The increased access the Congress brought about in medicare and medicaid—did that have something to do with the increase?

Dr. ZAPP. There is no question it did.

Mr. ROY. You see what is really behind all this in addition to the things we have discussed; do you have any other factors you think are behind this? May I suggest the increase in the intensity of care, the amount of scientific know-how, the technological ability we have developed.

Dr. ZAPP. There is no question, as we become more sophisticated in the biomedical ends, we are able to give people more comprehensive treatment; and you know, as you develop your techniques for transplantation and open-heart surgery and other new skills, the high cost per illness is inevitable. People tend to live longer in those kinds of either chronic or very acute situations. That all adds to the health care experience.

Mr. ROY. Having examined briefly what you and I know to be the increases of the cost of health care, the fact it is rising twice as fast in cost as the general increase in the gross national product, doesn't it appear reasonable that we should build our health care system and that we should control, as much as possible, the scientific and technological changes within the health care system?

I am suggesting, for example: Doesn't it appear that it is expensive to duplicate facilities, it is expensive to treat people with inappropriate facilities and inappropriate personnel? Isn't it logical to do some of the things we have discussed?

Dr. ZAPP. I would think so. I would like you to enumerate on controlling the technique in scientific involvement.

Mr. ROY. We cannot do all things for all people at all places as far as the delivery of health care. We have to select carefully, to make sure that regional centers do reach the population and not duplicate and, at the same time, make sure we have proper personnel to give the service. Do you agree?

Dr. ZAPP. We would be in substantial agreement on that statement.

Mr. ROY. I think we have wide areas of agreement. The thing that troubles me is what I see is under this tremendous pressure of costs; I know it is there and you know it is there; yet the administration is being very shortsighted and saying, "We are going to do little or nothing about building the system; we are going to remove Federal dollars not only here but from the system generally. We are going to put little or no money into increased comprehensive health planning. We will take away the technical assistance available in regional medical programs. We will take away any number of things." Which adds up to a retreat of this administration from building the health care system and the growth of the health care system. The very factors most responsible for cost.

My feeling is that national health insurance is not the No. 1 priority. If we go to that now, it will be like throwing a bucket of gasoline on a fire. You are dismantling the fire department, firing the firemen, taking away the trucks, and this inflation goes on and on.

This is the reason I say, with total conviction, that it least as far as you have demonstrated to date that this administration has no policy. I has a bunch of accounants, businessmen, and industrialists looking at an emergency situation where we are spending too much money on health and saying, "Cut out the community mental health centers. We won't do a thing to control the uncontrollables—in other words, the inflation of costs in the Federal health delivery financing programs, the uncontrollables of Medicare and Medicaid—and that has an effect on the Federal budget."

I go into this because I think it is pertinent to what we are talking about here today. We will be talking of it in the future and have talked about it in the past, to try to demonstrate to you we have wide areas of agreement.

Somebody in OMB or whoever is left in the White House, is making absolutely totally absurd decisions that you, out of conviction or for other reasons, are coming up here trying to impose upon us.

Dr. ZAPP. Mr. Roy, I first of all would say I think we have wide areas of agreement as we assess the system; we have wide areas of agreement in the interpretation of what the administration is proposing as part of its health strategy. I don't think we are tearing down the firehouse; I think we may say a simple firehouse has been built and, whether we need to build one in each of the suburban housing developments, one may get built whether we do it or not.

Mr. ROY. We are going to HMO's, and I have a paper in which HEW says we can save probably $20 million by the establishment of HMO's. Under the fine scalpel of a surgeon named Todd and the urging of the White House, the administration has reversed its position in 1972, which Dr. Todd then bragged about. Todd went to the White House and said he couldn't get millions of dollars from physicians if we had HMO, an assistance program. HEW documented HMO's would save money, but this administration changed its policy based on other considerations.

Dr. ZAPP. We were before this committee with Undersecretary Carlucci some weeks ago in what you may call a redefinition of our HMO position. If you feel we are saying something different, yes, we are stating it should be. As I recall, he was highly complimented by the chairman for that different definition.

We stated, for the purposes of HMO's: We feel a 5-year demonstration project is appropriate. We feel the Federal role may differ a little on a substantive basis from what the committee may be selecting at this time. We feel perhaps we had oversold ourselves in the past. Dollar levels are the same, what we were proposing in fiscal 1974, if the HMO Act was the same as it would have been last year.

We made some changes—that we should preempt State laws, and some other issues. We don't think it should be subsidized. That gets back to the point you made about assistance.

Mr. Roy. I feel totally they should stand on their merits and be competitive. I have no problems with that. I have problems with this baloney approach, of taking a slice here, a slice there. Of backing away from all the existing programs, from the HMO programs, from all proposed programs, from other programs within HEW.

I agree these thinge need to be looked at. I know the problems with RMP. I know all these problems. But I find, when you analyze the thing, it is a shrinking programmatic approach to overwhelming problems. We both spent our lives as health professionals, and we are greatly concerned that the people of this country get health care at a price they can pay. They can't get it now because Mr. Nelsen's medical school doesn't get enough money to train personnel. They can't get it now because they don't have enough appropriate places to give it, community mental health centers and so on. And costs will be so great in the future if we go to national health insurance without doing something about the system; we will have exactly what you argue against—arbitrary, centralized controls. These are present right now in the Cost of Living Council, which is saying, in essence, to our health care providers: Regardless of what your costs are, you increase your fees or charges only by, say, 2.5 percent or some nonsensical figure like that, and then we will make a dozen exceptions and have red tape up to our ears.

This is where we will have an arbitrary, centralized control of the health system done by accountants who are totally unable to look at our problems and proceed with Federal assistance to solve those problems. It is something I can almost get emotional about.

Dr. Zapp. I could almost get emotional about responding on some of those comments. I am not sure what length the Chair would desire that we go into it. I will be before the committee tomorrow, discussing that issue. I would want the record to show I would take objection to some of those statements.

Mr. Roy. Your actions speak very clearly. I think there has been a saying by a former Attorney General, "Watch what we do, not what we say."

Mr. Rogers. That is inoperative now.

Thank you for being here. We appreciate your testimony. You are always trying to give the viewpoint of the administration, no matter what it might be, and let each committee member give his.

Dr. Zapp. I know, when we have a full morning like this, we have many things of interest to discuss.

Mr. Rogers. Thank you. You are very helpful, and we appreciate your good work.

[Testimony resumes on p. 36.]

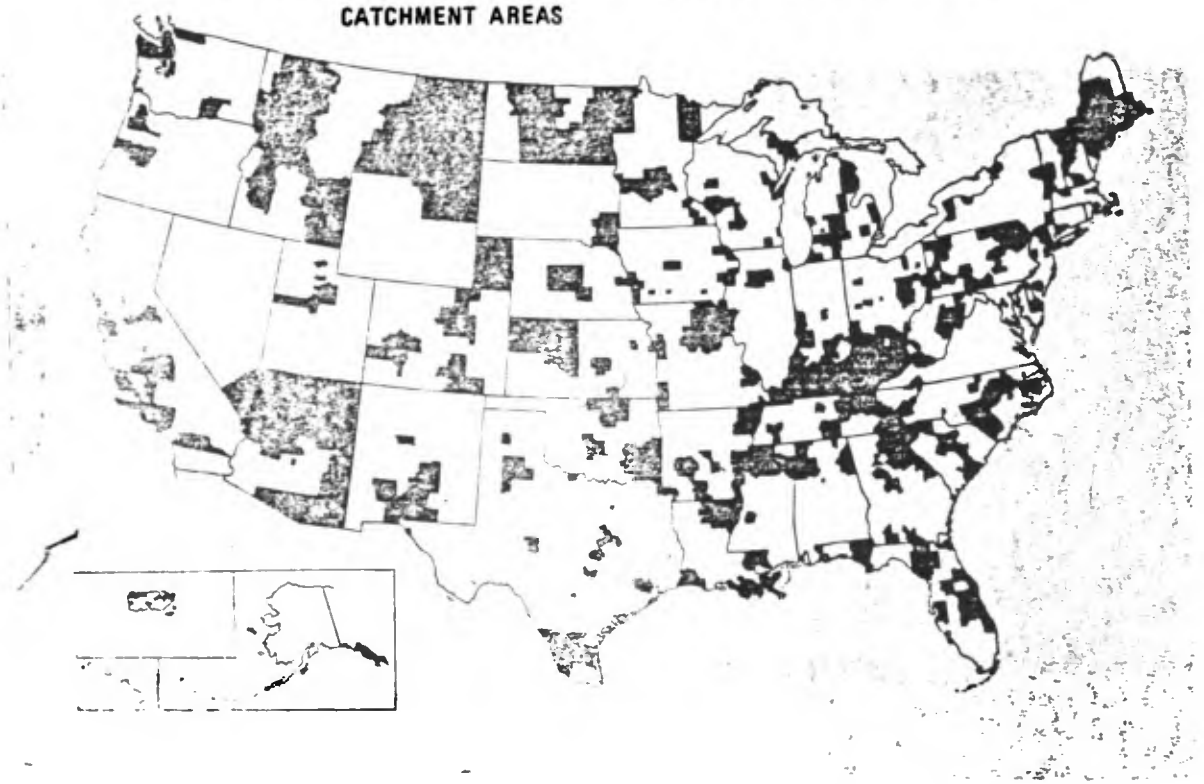
[The following questions from Congressman Symington and HEW's answers were received for the record:]

QUESTIONS SUBMITTED BY CONGRESSMAN JAMES W. SYMINGTON AND ANSWERS SUPPLIED BY HEW

Question No. 1. Please provide a map or listing of all CMHC cachment areas. What percentage of each state is covered by a CMHC cachment area? Please identify the shortage areas.

COMMUNITY MENTAL HEALTH CENTERS

CATCHMENT AREAS



PERCENTAGE OF STATE POPULATION LIVING WITHIN FUNDED CATCHMENT AREAS

State	Number of funded centers	Percent State population covered by centers
Region I:		
Connecticut	5	24.5
Maine	7	92.5
Massachusetts	14	35.4
New Hampshire	2	26.8
Rhode Island	1	9.9
Vermont	2	28.6
Region II:		
New Jersey	15	34.3
New York	22	26.6
Puerto Rico	9	49.1
Virgin Islands		
Region III:		
Delaware	2	50.7
District of Columbia	4	100.0
Maryland	10	31.4
Pennsylvania	37	47.1
Virginia	6	23.4
West Virginia	7	60.9
Region IV:		
Alabama	8	35.4
Florida	14	32.7
Georgia	13	42.1
Kentucky	23	97.1
Mississippi	7	50.4
North Caroline	19	54.8
South Carolina	7	60.0
Tennessee	10	42.0
Region V:		
Illinois	13	14.5
Indiana	8	26.8
Michigan	15	26.0
Minnesota	7	26.7
Ohio	14	21.4
Wisconsin	12	39.8
Region VI:		
Arkansas	8	59.1
Louisiana	13	37.9
New Mexico	3	37.0
Oklahoma	4	34.7
Texas	24	31.4
Region VII:		
Iowa	5	25.3
Kansas	9	72.8
Missouri	10	29.1
Nebreska	4	31.8
Region VIII:		
Colorado	11	67.9
Montana	4	78.0
North Dakota	5	80.5
South Dakota	1	29.3
Utah	6	76.9
Wyoming	2	44.5
Region IX:		
American Samoa		
Arizona	6	54.7
California	44	30.3
Guam	1	77.0
Hawaii	4	54.0
Nevada	1	28.6
Trust territory		
Region X:		
Alaska	2	10.4
Idaho	5	74.8
Oregon	2	17.0
Washington	6	22.6

Question No. 2. What is your estimate of the number of people in need of CMHC services?

Answer. The community mental health center program is designed to provide community based mental health services to all those who need them. While it is difficult to arrive at precise figures of need, it is generally estimated that some 10 percent of the population is in need of some form of mental health care. Not all these people, however, seek mental health care. The community based approach to mental health service delivery promotes early and effective intervention, enabling people to seek care close to home.

Question No. 3. What is your estimate of people now served by CMHCs?

Answer. Some 76 million people now live in areas covered by funded community mental health centers, though not all funded centers are yet operational. Some 700,000 people received care at the 295 operating community mental health centers during 1971. In addition, many other people were reached through the CMHCs indirect services of community consultation and education.

Question No. 4. If this Federal program is discontinued, may federally funded centers be used for other purposes? For example, if an institution has been awarded a CMHC construction grant—but now has little prospect of a staffing grant—may the building construction be used for other medical purposes?

Answer. Discontinuation of the program will not release applicants from their obligation to provide mental health services. According to law, (P.L. 88–164), community mental health centers constructed with Federal assistance are required to provide mental health services for a period of twenty years after completion of the facility. This is so whether or not subsequent staffing grant support becomes available. The unavailability of staffing grant funds is not regarded as sufficient cause for releasing an applicant from the obligation to provide mental health services.

Question No. 5. If not, how are centers constructed by Federal funds to be staffed?

Answer. Staffing grant support provides only a percentage of total staffing costs of a community mental health center. Further, the percentage of Federal support declines over time. Thus, community mental health centers, even those with staffing grant support, have had to seek additional sources of revenue to operate their programs. Nationwide, staffing grants provide only some 27 percent of community mental health center budgets. State and local funds, insurance and other third party payments, patient fees and philanthropy have contributed to community mental health center budgets. In the absence of staffing grant support, non-Federal sources of funds will be required to staff and operate community mental health centers.

Question No. 6. What is your cost estimate of staffing a CMHC serving a catchment area of 200,000 people?

Answer. While there is some difference between rural and urban community mental health centers in this regard, on average, the cost of staffing a community mental health center serving a catchment area of 200,000 people is approximately one million dollars.

Question No. 7. Should CMHCs in rural areas be required to provide transportation service to those desiring to utilize the center's services?

Answer. No. Centers in rural areas have been innovative in the development of techniques to deliver mental health services (traveling teams, satellite units, closed circuit TV, consultation with community caregivers) in order to reach those persons in need of mental health care. In certain instances, providing transportation may be an appropriate method, but our experience indicates that it is not neecssary to require it in order to deliver effective mental health services in rural areas.

Question No. 8. Should CMHCs in urban areas be required to provide outpatient services at night and on weekends? What percentage now provide such services?

Answer. The provision of accessible outpatient care is an essential aspect of CMHC service delivery. About half of the operating CMHCs now provide outpatient service, nights and weekends. We are considering the requirement that all CMHCs, in rural as well as urban areas, provide a portion of their outpatient time on nights and weekends.

Question No. 9. Please summarize the findings of the $91,000 contract with New York State's Department of Mental Hygiene. This is contract number HSM–42–72–53 and the project officer is Dr. Morton Kramer. To what degree were residents receiving mental health care in the given catchment areas?

Answer. NIMH Evaluation Study HSM–42–72–53 with the New York State Department of Mental Hygiene was designed to provide an indepth study of patterns of mental health service utilization by residents of one catchment area only. The study found a significant decrease between 1971 and 1972 in inpatient admissions of catchment area residents (—16%), regardless of the location of the facility. At the same time, of those catchment area residents actually admitted to inpatient care, the percentage treated by the CMHC increased from 38.4% to 49.7%.

Overall, of residents admitted to all kinds of mental health services, about 70% were served by facilities located inside the catchment area. Of the persons

receiving care within the catchment area, over 50% received care at the CMHC.

The summary findings were that the CMHC played a substantial role in the provision of services to residents of its catchment area, and the majority of catchment area residents served received treatment in the catchment area. Referral of clients to the Center was found to be inhibited by a number of factors, principally, waiting lists, cultural homogeneity of Center staff, insufficient Center contact with the referring agency, and client reluctance to be treated in a Center set in a large city hospital.

Question No. 10. Please summarize the findings of the $100,000 contract with A. D. Little studying the viability of the catchment area concept. This was contract number NIMH–OPPE–72–96 and the project officer was Paul Ahmed.

Answer. In 1972, a contract was awarded to A. D. Little, Inc. to evaluate the viability of the catchment area concept. The specific objectives of the study are:

(a) Determine whether the catchment area concept has led to useful and realistic boundaries, or has interfered with with the efficient delivery of services.

(b) Determine whether the concept has helped or hindered the integration of mental health and other human services.

(c) Determine whether the intent of the regulations to insure that CMHC's take responsibility for serving the mental health needs of a specified population has been followed.

(d) Determine the reasons why persons from a given catchment area might utilize the CMHC of a different catchment area.

The study is still in process. The contractor has finished analysis of internal documents such as grant applications, site visit reports, and others. Preliminary analysis indicates that the catchment area concept has facilitated the planning of community programs. The field work is awaiting OMB clearance, and will be started as soon as the clearance is received.

Question No. 11. Please summarize the findings of your $75,000 study with Littlejohn Associates to determine the effects the 1970 amendments had in helping to service the poor in catchment areas. This was contract number HSM–42–72–89 and the project officer was Dr. Ralph Kennedy.

Answer. A study of the impact of preferential poverty funding, provided under 1970 amendments to CMHC legislation, was commissioned to Roy Littlejohn Associates in 1972. The final report on the study has just been received, and points to the following conclusions:

(a) Programs in service outreach to the poor in designated Centers were generally strengthened by the award of preferential funds. The effect of being designated a "poverty center" was frequently reported by CMHC's as more significant than the preferential funds themselves. Such designations enabled CMHC's to obtain other funds for programs like alcohol and drug abuse.

(b) The "Small City Group" Centers reported the greatest number of changes in program configuration and in services due to poverty funding, and this tended to be reflected in the staffing of new satellite service units in outlying areas. (These Centers, mostly hospital based, started with minimal services for the poor.) Rural CMHC's reported the greatest number of changes in staffing. In metropolitan centers, poverty funds did not have measurable effects because of funding complexities and size, and they did not report many changes attributable to poverty funding.

Question No. 12. Please summarize the findings of your $100,000 study with Behavior Science Corporation regarding the effectiveness of CMHC as school consultants. What effect have CMHC personnel had as school consultants. This was contract number HSM–42–72–110 and Paul Ahmed.

Answer. A contract was awarded in 1972 to the Behavior Science Corporation to assess the impact of school consultation programs in CMHC's. Although the field work is finished, the final report is not yet complete. The tentative conclusions of the study are:

(a) Mental health consultants need more training in the educational process and in advising on the problems of guidance counsellors and principals.

(b) School counsellors and guidance personnel are not adequately trained for mental health counseling. Counseliors need more training in dealing with children with mental health problems.

(c) Mental health consultants, often paraprofessionals, similarly are untrained. NIMH needs to provide the specific tools to train them as school consultants.

Question No. 13. Please summarize the findings of your $35,000 contract with the Bureau of Census regarding shifts in Mental Health Services' Financing by state and local governments. To what extent have states picked up the financial burden? Please provide a state by state breakdown of state financial support for CMHCs. The project officer on this contract or intragovernment agreement was Maggie Conwell.

Answer. In 1972, the Bureau of the Census agreed to trace, as nearly as possible, the trends in which various mental health activities are supported financially over a period of time, whether by State, Federal, or State-local revenues. The survey is of limited help, since Census found that the accounting systems in the ten states surveyed were not capable of identifying funds by source at major points of transfer. The sparse data available yielded few reliable conclusions. Generally, while the absolute amount of Federal support for mental health services increased between 1970 and 1971, the amount of State and local funding increased even more. Federal funds are now used by States primarily for psychiatric hospital services and secondarily for community mental health services.

The attached data, based on CMHC reports for 1971 in the NIMH Inventory of Community Mental Health Services, shows the relative support of Federal, State, and other Government funds for CMHC's.

PERCENT DISTRIBUTION OF SOURCE OF FUNDS, BY STATE AND GEOGRAPHIC REGION, FEDERALLY FUNDED COMMUNITY MENTAL HEALTH CENTERS, UNITED STATES, 1971[1]

State and geographic region	Number of CMHC's	Number CMHC's reporting	Total funds (percent)	Total government funds (percent)	Federal funds				State funds (percent)	Other government funds (percent)
					Total (percent)	Federal staff (percent)	Federal construction (percent)	Other Federal (percent)		
Total [1]	295	210	100	72.2	34.0	27.4	3.1	3.5	28.7	9.5
Region I	18	11	100	79.5	54.5	24.2	14.8	15.5	23.7	1.3
Connecticut	2	1	100	38.3	34.7	0	34.7	0	3.6	0
Maine	4	4	100	69.6	51.7	50.1	0	1.6	13.1	4.9
Massachusetts	9	4	100	85.5	58.1	18.5	18.2	21.4	27.0	.4
Vermont	2	2	100	73.5	40.8	28.5	7.8	4.5	31.6	1.4
Region II	24	12	100	68.1	26.2	24.9	.4	.9	24.6	17.2
New Jersey	3	2	100	52.7	44.6	40.8	3.8	0	7.4	.7
New York	13	8	100	69.5	23.6	23.0	0	.6	26.1	19.9
Puerto Rico	8	2	100	83.7	36.9	23.1	0	13.8	45.0	1.8
Region III	33	23	100	79.4	38.0	34.9	0	3.1	32.7	8.7
Delaware	2	1	100	60.0	33.1	33.1	0	0	26.9	0
District of Columbia	3	1	100	77.5	31.8	31.8	0	0	0	45.7
Pennsylvania	21	18	100	80.3	38.9	35.2	0	3.7	37.7	3.6
Virginia	2	1	100	58.7	27.2	27.2	0	0	15.8	15.7
West Virginia	2	2	100	86.8	46.9	46.5	0	.4	16.5	23.5
Region IV	68	51	100	76.0	41.2	33.8	.9	6.5	24.4	10.4
Alabama	4	1	100	56.9	17.2	5.0	0	12.2	39.7	0
Florida	11	7	100	61.2	42.3	41.6	0	.7	9.3	9.6
Georgia	6	1	100	72.1	0	0	0	0	34.6	37.4
Kentucky	21	19	100	83.2	54.4	43.3	0	11.1	26.4	2.4
Mississippi	5	4	100	82.5	57.9	57.9	0	0	0	24.7
North Carolina	10	10	100	91.8	24.0	23.1	0	.9	37.6	30.2
South Carolina	4	4	100	71.2	34.3	34.3	0	0	18.8	18.1
Tennessee	7	5	100	84.6	59.3	38.5	9.0	11.8	18.3	6.9
Region V	33	19	100	78.6	26.0	19.1	6.5	.4	37.2	15.4
Illinois	4	3	100	74.4	37.7	24.5	12.0	1.2	32.7	4.0
Michigan	11	6	100	70.7	18.9	18.9	0	0	14.7	18.0
Minnesota	2	4	100	78.6	24.6	16.1	7.8	.7	15.5	3.4
Ohio	6	2	100	60.6	46.0	11.0	0	0	11.0	3.7
Wisconsin	5	3	100	91.2	14.3	3.0	11.3	0	44.3	32.7

Region VI	34	27	100	74.7	38.1	33.7	1.9	2.5	26.5	10.1
Arkansas	6	5	100	80.0	47.2	40.5	5.1	1.6	31.4	1.4
Louisiana	9	6	100	80.2	34.2	28.1	6.1	0	45.3	.7
New Mexico	2	2	100	81.2	44.8	36.6	0	8.2	33.8	2.6
Alabama	3	2	100	64.7	52.2	50.6	0	1.6	5.6	6.9
Texas	14	12	100	70.9	31.2	29.8	0	2.4	19.5	19.2
Region VII	14	8	100	53.5	31.5	20.0	10.2	1.3	4.7	17.2
Iowa	3	1	100	75.0	36.3	7.8	28.0	.5	0	38.6
Kansas	4	4	100	46.3	26.9	17.6	8.0	1.3	4.8	15.1
Missouri	5	2	100	48.9	44.7	42.2	0	2.5	4.2	0
Nebraska	2	1	100	92.8	43.1	43.1	0	0	36.2	13.4
Region VIII	19	17	100	88.6	38.5	37.2	.2	1.1	37.1	13.0
Colorado	8	8	100	90.8	40.8	39.4	.3	1.1	38.1	12.0
Montana	2	2	100	93.0	43.3	43.3	0	0	39.6	10.1
North Dakota	5	3	100	57.7	20.3	20.3	0	0	15.7	21.7
Utah	3	3	100	93.4	35.4	35.8	0	.1	44.1	14.0
Region IX	41	33	100	59.1	23.2	19.2	2.9	1.1	30.5	5.5
Arizona	4	4	100	39.4	34.9	26.7	7.5	.7	3.6	.9
California	34	27	100	61.8	21.2	17.9	2.2	1.1	34.5	6.1
Hawaii	2	2	100	78.4	26.1	26.1	0	0	46.5	5.8
Region X	11	9	100	70.3	45.7	38.8	0	6.9	20.3	4.2
Idaho	4	4	100	90.2	41.1	40.6	0	.5	48.7	.8
Washington	4	4	100	63.6	55.0	42.6	0	12.4	5.1	3.6

[1] Those States have been omitted where fewer than 2 community mental health centers have reported. Thus the total number of community mental health centers for the United States and the regions will not equal the sum of the centers by States.

Question No. 14. Please summarize the findings of your $91,000 contract with the University of North Carolina. What impact evaluation methodology was developed? What methodology is most effective in measuring the worth of catchment areas and CMHCs? This was contract number HSM-42-72-120 and the project officer was Dr. Morton Kramer.

Answer. Contract #HSM-42-72-120 was awarded to the University of North Carolina to conduct a planning study to determine the feasibility of designing and implementing an evaluation protocol which would provide an integrated assessment of the impact of a CMHC program on the population of the catchment area where the center is located, on the persons who receive direct services from the center and on the organizational structure of the community. The contract was funded for one year with an expected termination date of May 25, 1973. Because of the complexity of the issues being addressed, the terminal date of the contract was extended, with no additional funding, to September 30, 1973, to permit the Task Forces (described below) to have sufficient time to carry out their work in a thorough and careful manner.

To implement this contract, the Project Director established three Task Forces: community organization, population assessment and services evaluation, consisting of 30 high-level people selected from various departments of the University and from the North Carolina State Department of Mental Health. Each Task Force reviewed the literature of relevant fields and met with evaluators from various parts of the U.S. to learn of methods and techniques not yet published.

The Task Forces have utilized the information so gained to prepare recommendations for studies to be carried out and techniques to be used. The Steering Committee of the project is currently studying the following methodologies, and will develop formal procedures for their implementation in a Final Report to be submitted to the NIMH in September 1973:

1. Methods for the assessment of the internal structure and external (interorganizational) relationships of CMHC's as these relate to the effectiveness of services rendered, as well as the coordination and integration of mental health with other human service delivery systems.
2. Measures of treatment effectiveness of the various program elements engaged in direct clinical services which involve assessment of client performance (in terms of social, societal, intra- and interpersonal functioning) prior to and after receipt of services including follow-up in the community.
3. Methods for assessing need for mental health services:

a. as measured directly in the general population by way of epidemiological techniques and

b. as measured indirectly among the caseload of the mental health center and its referral sources through the use of appropriate criteria whereby the extent to which current professional standards of treatment are followed in the management of selected clinical conditions.

4. Methods for determining the quality and effectiveness of mental health consultation services in terms of changes produced for the consultee and the client.

In addition, the current state of the art in cost-effectiveness methods is under review, and the contractor expects to incorporate such procedures in the protocol during the course of the field demonstration as specific methods are developed and as funds are available for this activity.

The two questions raised by Mr. Symington—namely, what impact methodology was developed and which methodology is most effective in measuring the worth of the catchment areas and the CMHC's—cannot be answered at this time through this project. This project is a feasibility study designed to determine the extent to which existing knowledge can be applied to accomplish the stated objectives of this project. As indicated, the focus was to review the available methodologies and measurement techniques and to determine which appear to be the most promising for the stated purposes. The contractor will then develop protocols for an integrated evaluation plan and an organizational structure for implementing it. The various protocols in the plan will require field testing in one or more ongoing CMHC's. Since no actual program evaluations were scheduled for completion during the period for which this contract was awarded, judgments with respect to the relevant merit of the proposed methodologies must await these field demonstrations.

Mr. ROGERS. We now have a distinguished panel we would like to hear, Mr. Jonas Morris from the community mental health centers,

Washington, D.C.; Dr. John Carver, director of the Mental Health—Mental Retardation Authority of Harris County, Houston, Tex.; Mr. Elmer Ediger of the Prairie View Mental Health Center, Newton, Kans.; and Dr. Herbert Diamond, medical director, West Philadelphia Community Mental Health Consortium, Pa.

STATEMENTS OF A PANEL REPRESENTING THE NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS: JONAS V. MORRIS, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS; JOHN CARVER, PH. D., EXECUTIVE DIRECTOR, MENTAL HEALTH—MENTAL RETARDATION AUTHORITY OF HARRIS COUNTY, HOUSTON, TEX.; ELMER EDIGER, ADMINISTRATOR, PRAIRIE VIEW MENTAL HEALTH CENTER, NEWTON, KANS.; AND DR. HERBERT DIAMOND, MEDICAL DIRECTOR, WEST PHILADELPHIA, PA. COMMUNITY MENTAL HEALTH CONSORTIUM

Mr. MORRIS. Mr. Chairman, my name is Jonas Morris, and I am executive director of the National Council of Community Mental Health Centers. We are glad to respond to the subcommittee's invitation to testify at these oversight hearings on the community mental health centers program.

I have with me today three people who are involved in the day-to-day operation of community mental health centers and who will speak briefly about their programs after my own introductory remarks. They are: John Carver, Ph. D., director of the Harris County MH-MR Authority in Houston, Tex.: Elmer Ediger, administrator of the Prairie View MHC in Newton, Kans.; and Herbert Diamond, M.D., medical director of the West Philadelphia CMHC Consortium.

I have a prepared statement that I would like to have inserted in its entirety in the record if it is agreeable with the subcommittee, Mr. Chairman, and I would like to take a few moments to summarize.

Mr. ROGERS. Without objection, your statement will be made a part of the record following your summation.

Mr. MORRIS. Since these are oversight hearings, we believe the most productive use of the subcommittee's time will be in asking us questions. Therefore, we will keep our opening remarks very short.

Page 2 of our testimony speaks to the program of the national council, what it is that we do for our members or plan to do as our capacity grows. One of the principal responsibilities of the council, as we point out, is to develop a system that insures to the fullest extent possible that the CMHC program is as good as possible. This means delivering effective mental health services for as low a cost as possible and delivering services that are responsive to the needs and the wishes of the community served.

And linked to the issue of adequate monitoring and accountability of federally funded programs is the need for effective evaluation, to which NCCMHC is also devoting considerable energy.

On page 3 we discuss the issue of funding CMHC's and the alternatives to the existing categorical grant programs. We are not wedded to the concept of categorical grants, but existing alternatives, such as

medicaid and medicare, now provide only a small proportion of the income to centers—4 percent and 2 percent, respectively.

While centers could undoubtedly take greater advantage of these programs than they currently do, we know there are barriers to using them effectively as a financial resources. We also know, as we describe, that it will be difficult to raise on a local basis the additional dollars necessary to replace Federal dollars.

On page 6 and following pages we speak to the question of the success of the program; and here, as I know you are aware, there is no dispute. The administration agrees that the program has been a success.

Our testimony runs down the myriad of problems centers are dealing with today—from drug abuse to alcoholism to children's problems—and some of the gaps in service that would confront us if the CMHC program were aborted at this time.

On page 9 we talk about the changes that the national council would like to see in the CMHC program in order to strengthen it and improve it. We know the subcommittee is not considering substantive renewal of the act at this time, but we anticipate that at some point you will, so we bring these thoughts before you now.

Mr. ROGERS. And we will.

Mr. MORRIS. Good. Finally, on pages 11 and 12, we speak to the need for developing new community mental health programs. The original legislation established the Federal commitment of a national coverage of these services. Thus the program is not a demonstration program but one designed to insure that all Americans have access to community mental health services. We now have 389 operating community mental health programs, and we need a minimum of 1,500 in order to provide full coverage.

The initial investment required to launch a center is substantial, and experience shows that, in order to begin the kind of comprehensive program required, we need the Federal input; States and localities generally don't have this capacity. We refer to a study which shows that the Federal contribution makes a significant difference in launching new programs.

We discuss on page 12 and include in the appendices, the number of centers which are developing toward a comprehensive model—programs that more than likely will stay in the gestation stage unless Federal dollars are available.

In response, Mr. Chairman, to some of the questions or issues brought up earlier, I would like to mention briefly the impoundment situation. We in our analysis of the continuing resolution under which DHEW is currently operating, find there is approximately $40 million available for new starts in fiscal 1973 which the administration is not using.

Mr. ROGERS. How much?

Mr. MORRIS. $40 million, and we believe and hope some action will be taken to release these dollars.

Mr. ROGERS. This is for new starts:

Mr. MORRIS. This would be for new starts—not continuation money, but new starts.

Also, with regard to revenue sharing, we have a brief summary here of material we have prepared that shows how our community mental

health centers are now using general revenue sharing dollars. We have this question of all the members of the National Council and find the members do not have full access to these dollars because competition is so strong, and there are other problems.

The general amount of revenue sharing dollars that becomes available to centers is in the neighborhood of $2,000 to $3,000. Requests are in the neighborhood of $40,000 to $50,000.

Also we surveyed our members with regard to what would be the effect of terminating the program, and I have this document I would like to submit for the record.

Mr. ROGERS. Without objection, it will be made a part of the record.

[See "General Revenue Sharing Funds Use by CMHC's," p. 47.]

Mr. MORRIS. It shows the centers will have a very hard time. Those centers now operating will, at some point, have their dollars terminated, and programs that would like to get off the ground with the new staffing grant will have a very hard time according to their own analysis of the situation. This is the kind of survey you were asking HEW witnesses for.

Mr. ROGERS. Yes.

[The testimony resumes on p. 70.]

[The national council's prepared statement with attachments and the report on general revenue sharing, referred to, follow:]

PREPARED STATEMENT OF A PANEL REPRESENTING THE NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS: JONAS V. MORRIS, EXECUTIVE DIRECTOR, NCCMHC; JOHN CARVER, PH. D., EXECUTIVE DIRECTOR, HARRIS COUNTY MH-MR CENTER, HOUSTON, TEX.; ELMER EDIGER, ADMINISTRATOR, PRAIRIE VIEW MENTAL HEALTH CENTER, NEWTON, KANS.; AND HERBERT DIAMOND, M.D., DIRECTOR, WEST PHILADELPHIA, PA. COMMUNITY MENTAL HEALTH CONSORTIUM

Mr. Chairman, Members of the Subcommittee, we appreciate the opportunity to testify in connection with these oversight hearings on the community mental health centers program.

The statement is presented on behalf of the National Council of Community Mental Health Centers, a nonprofit organization established in 1970 and representing 293 agencies concerned with the delivery of community mental health services. 215 of these members are operating comprehensive community mental health programs, and 202 of them receive federal staffing assistance. Another 78 are agencies aspiring to the comprehensive model or other agencies which do not offer services but are nevertheless deeply involved and committed to the community mental health concept.

We are speaking to you today, then, on behalf of professionals engaged in the delivery of mental health services through community programs. Our primary concern at this time is the uncertain future for the community mental health movement in light of the Administration's current position; especially the question of whether the concept will grow and be improved upon, or whether it will stagnate and retrench causing unnecessary suffering and human tragedy.

Regardless of how the federal role vis a vis community mental health centers may develop, it is essential to ensure that the existing programs provide the best possible services to their communities. Thus, NCCMHC is always eager to explore possible deficiencies in the program with an eye toward its improvement.

Since its formation in 1970, NCCMHC has gradually expanded its own role in the area of technical assistance to encourage the improvement and expansion of community mental health services. We now provide technical assistance to developing and existing programs through consultation services, educational workshops, and frequent other meetings which provide a forum for exchanging new ideas.

Over the last few years, the National Council has also been working increasingly with the National Institute of Mental Health to improve regulation of the federal program. We are genuinely concerned that some community mental health centers are not living up to their potential. Much could be done to

strengthen the monitoring system and to provide assistance to those programs now failing short of their goals or which have run into difficulties for a variety of reasons.

Linked to the question of adequate monitoring and accountability of federally funded programs, is the need for effective evaluation of services.

NCCMHC is working with the Accreditation Council for Psychiatric Facilities on standards for community mental health centers, placing particular emphasis on the delivery by the centers of those services needed by their community. We need to devise methods to determine those needs effectively and to develop ongoing performance criteria for CMHC's. AC/PF will probably promulgate standards for CMHC's within the next six months, and centers will have to meet the standards if they are to qualify for any private third-party payments for which they might be eligible. Unfortunately, though, sources of third-party payments—private or public—for CMHC's are extremely limited.

We are thus fully aware of the difficulties facing many CMHC's, and of the shortfalls that have occurred in the federal program. Yet we firmly believe that without a federal role the task of expanding community mental health services in which we are engaged will become harder and harder.

Our concern over the question of further funding for these centers is greatly heightened by the overwhelming lack of evidence and hard data in support of the claims now being made that third party payments, patient fees, and state and local governments can support the continued growth of the community mental health concept. Our own experience and knowledge of the situation points to just the opposite conclusion. It seems highly unlikely that these alternative funding sources can continue the existing services, let alone expand services to new communities.

This is partly a question of timing. As yet, we have no system of national health insurance, and cannot realistically expect such a system to go into effect for a minimum of three to four years. Governmental insurance programs—Medicare and Medicaid—are not at this time providing significant income to community mental health centers (1.7% and 3.9% of total center receipts respectively). In large part this is a result of inadequacies in coverage under Medicaid in many states, restrictive laws in some states which prevent CMHC's from receiving any payments for services to Medicaid recipients, and the fact that although many center patients are unable to pay for all the services they receive from centers, they are not quite poor enough to qualify for Medicaid. Patient fees are based on a sliding scale, and since 64.3 percent of those receiving services have family incomes below $5,000 and 91 percent have incomes below $10,000, patient fees constitute merely 8 percent of center receipts.

States and localities now contribute a fairly significant amount to community mental health centers, but are finding it very difficult to substantially raise this assistance. Many localities are restricted by mill levies from increasing their mental health expenditures; states are faced now with the burden of carrying on the many health and social service programs which the federal government will no longer support, and provided with federal revenue sharing payments totalling less than the total amount needed for existing programs. Furthermore, states cannot be expected to act overnight to pick up these costs. Some legislatures meet only every other year for budget matters and have already ended their current sessions. Centers in these states cannot turn to the state for assistance before 1975, when appropriations for FY 1976 will be made. This is no way to operate a responsive and responsible community program.

Something, we submit, must be done to tide the centers over until such time as there is an alternative funding source (such as national health insurance) or until we can be absolutely sure that states and localities can indeed bear this burden.

Revenue sharing has been termed the solution to this problem, but revenue sharing has the appearances of a red herring. No special revenue sharing for health is to be proposed, according to HEW Secretary Weinberger, for some time, certainly not during FY 1974. General revenue sharing is now cited as a substitute for a whole range of service programs being phased out, but is being used for construction projects and other one-shot expenditures by states and localities which have come to doubt the depth of the federal government's commitment to financing state and local programs. According to an NCCMHC survey, only 22 centers have received financial aid as a result of revenue sharing payments, one from a state agency the remaining 21 from localities. In most instances the amount of this assistance was not very high—less than $5,000.

The fact is that states and localities, even with revenue sharing assistance, are unable to support CMHC services at current levels. And no one in the Administration has yet come forth with substantial evidence to dispute this fact.

NCCMHC is certainly not unwilling to consider alternatives to the existing grant program, and indeed would like to see many changes made in the current law. A year before the President's FY 1974 budget was released NCCMHC adopted a recommendation that direct services of a community mental health center should be supported in the long term by national health insurance, while indirect preventive, evaluation and research activities should be supported by the federal government under some continuing grant system which could, at the same time, ensure accountability to national priorities and needs, as well as ensuring minimum standards for the operation of CMHC's. Finally, the NCCMHC position calls for short-term two year operating grants to encourage the development of new community mental health centers.

This concept is entirely consistent with the Administration's own stated position calling for capacity building by the federal government, but removing support for direct health care services into a system of national health insurance where the patient would be free to make his own choice in the market place.

The Administration, of course, has not denied the value of community mental health care nor the successes of the existing federal program. Neither has it denied the seriousness of the need, nor the consequences of leaving untreated mental impairments and behavioral and emotional disorders.

Although we have provided data on the CMHC program to this Subcommittee before, we believe it is important to remember that this is one federal program which has achieved considerable success. We would therefore repeat here for the record some of the statistics which support our contention that we cannot afford to ignore the pressing mental health needs by abandoning the federal commitment to community mental health centers:

The resident population of state mental hospitals has been cut in half since 1957—from 570,000 to 275,000 in 1972, in large measure as a result of the federal program.

Where a community mental health center has been operating for three years or more fewer than half as many patients (per thousand people in the catchment area) are referred to a state institution than from areas not served by a center.

The costs of care are dramatically lower in community mental health centers than in large state institutions ($4,749 in institutions compared to $380 in centers, per patient care episode), a direct result of the minimal use of inpatient facilities by CMHC's.

The average length of inpatient care provided by a center is kept to a minimum—54 percent of the centers report an average length of stay of under 20 days and 41 percent of under 14 days. (Long-term inpatient care is, of course, undesirable for most mental conditions.)

Community care for the mentally ill has resulted in better care for the average American and for those who cannot afford the cost of private care, the federally funded community mental health centers program offers the major hope for effective treatment and perhaps the only alternative to institutionalization.

Community care enable the patient to remain in his community and to return more quickly to a fully productive life—potential savings of all persons had access to such care is in the billions of dollars.

The federally funded community mental health centers treated approximately one million people in 1972. As a result of the accent on community care most of these people can expect to return to normal and happy lives with their families, and the vast majority of them can continue to work and live at home while they receive care and attention from the center. Currently, it is estimated that something like $20 billion is lost in productivity each year as a result of mental illness, over $4 billion of which is a direct loss of tax revenue. Yet maintaining the CMHC program need cost the federal government no more than $200 million per annum.

The costs of mental illness and emotional problems are very often hidden. While the reduction in state mental institution resident patients and the savings which accrue from this reduction are often cited, what is frequently forgotten is that:

Nine million Americans are problem drinkers or alcoholics, one-third of all suicides, one-half of all homicides are alcohol related, and the number of alcoholics is rising year by year.

35,000 highway deaths per year are related to alcohol abuse.

It bas been estimated that almost balf of the crime perpetrated in America involves persons under tbe influence of alcohol.

600,000 Americans are heroin addicts, a very large proportion of wbom commit crimes in order to maintain tbeir habits.

Approximately half the calls to which tbe police respond involve marital or family disputes wbich could be more appropriately bandied by a crisis intervention team of a community mental bealth center, enabling the police to concentrate their resources on more serious crimes.

The costs—in botb federal, state and local tax dollars—of these problems is enormous. To abandon our efforts to reacb tbe root causes, to leave the federally funded CMHC program half-formulated, is a very unsound fiscal decision.

Can the Federal government really abandon:

The over 20 million of our citizens 65 years of age and older (a group especially vulnerable to mental illness and at tbis time receiving proportionately less treatment and rehabilitation tban any other group).

The 10 million children in need of mental bealth services (particularly while the number of admissions to public mental hospitals of those under 25 is continuing to rise).

Those suffering from one of the nation's primary mental health problems—depression (a recent survey indicates that 15 percent of all adults between 18 and 74 suffer significant depressive symptoms during any one year).

Nine million alcoholics, 600,000 drug addicts and millions of persons abusing drugs?

What would be the costs to these individuals and to society of leaving such conditions untreated? This is sometbing the National Council cannot estimate, but we do know that continuing the federal effort to establish community mental healtb centers across the nation will reduce the costs of treatment and that early diagnosis can prevent more serious conditions from developing in many cases.

As in any major program, tbe CMHC program as presently operated has some weaknesses and needs improvement. This improvement can best be achieved at tbe federal level, however. Turning the program over to states and localities will, in most instances, tend to perpetuate the status quo and reduce the flexibility of the program operators to respond to national standards or priorities.

Turning, just briefly, to some of the specific changes in the program and the legislation which NCCMHC would like to see adopted, and assuming that this Subcommittee will consider later this year an extension of the CMHC Act, we would like to recommend that all community mental healtb centers provide:

Comprehensive preventive and treatment programs for children with mental health problems and their families, together witb counseling for scbools and other community agencies dealing witb children.

Comprehensive programs for the mental health of the elderly—one of the groups most underrepresented in CMHC caseloads, and yet a group which is highly susceptible to mental disorders.

Comprehensive programs for prevention, treatment and rehabilitation of alcoholics.

Comprehensive programs for drug addicts in their catchment area (now required under PL 92–255, in large measure as a result of action by this Subcommittee).

Screening programs for all persons from the catchment area referred for treatment to a state mental hospital facility.

Aftercare programs for all persons released from state mental hospitals who reside in the center's catchment area.

Mental health services to any federally funded HMC which serves catchment area residents.

Accessible satellite program elements to ensure tbat every person in the catchment area has easy access to care.

An ongoing evaluation of the needs of the community served, and adequate public input into such evaluations.

Emergency services to all catchment area residents on a 24-hour a day, seven days a week basis, and other services during the evenings and on weekends to enable working people to receive assistance.

Some of these requirements are contained in legislation which passed the Senate during the last session. We hope that when this Subcommittee considers an extension of the CMHC Act which would make substantive changes in the existing law, tbat tbese additional provisions could be included.

In addition, there are some other administrative problems which have arisen in a number of centers, which should also be corrected through legislative action by the Congress. These issues include:

Occurrences whereby patients who can afford to pay for all services have been seen by center professionals not in the community mental health center to which the patient was first referred or admitted for care, but in their own private practice. This practice can result in serious losses of revenue for the CMHC.

The need for tightening of NIMH regulations regarding the appointment of professional staff in CMHC's to ensure that appointments are based entirely upon the qualifications of the individual and his suitability for the position in question.

The amount of professional staff time devoted to administration of the center, and the question of whether, in some instances, staff should be devoting greater proportions of their time to clinical services.

Despite these problems, however, the fact remains that through the CMHC program the federal government has stimulated development of comprehensive community mental health services and permitted the provision of unique systems of care for the mentally ill. The progress to date could not have been achieved without the federal role. To end that role now would be a tragic mistake.

The impact of the federal program is highlighted in a recent study by the National Study Service under an NIMH contract.[1] The researchers studied four counties in both 1958 and 1970 to determine the factors leading to changes in mental health programs, and to analyze the impact on the development of mental health resources of the establishment of federally funded CMHC's. Two of the counties studied were served by a federally funded center, while the other two were not.

The study concluded that:

"The study data and findings document and support several significant conclusions about mental health developments in these four counties. First, and perhaps foremost, there has been very substantial progress in the development of mental health resources in all four counties. However, the progress in the two counties with federal funding has been much more substantial than in the two that did not have federal funding.

"It is especially significant also that the federal funding enabled the community mental health centers in these two counties to invest much more time in activities other than direct services to clients, and thus to have substantially more impact in such important prevention areas as education and one or more other programs, such as corrections and vocational rehabilitation."

At this time, the CMHC program is still growing, and still evolving fairly rapidly as our experience increases. There is very strong support for the concept among professionals and among lay persons in communities served by centers and those where a program is currently being planned.

This is evidenced by the fact that there are at this time 68 communities which have applied for a CMHC staffing grant (through the regular program or for childrens services under Part F of the CMHC Act) and were approved by HEW (listed in Attachment I). These grants are unfunded, and will remain unfunded unless Congress acts to extend the legislation. In addition, there are hundreds of communities which were in the process of planning new community mental health services when the program abruptly ceased. (58 of which are listed in Attachment II).

There are also many communities (which received a construction grant under Part A of the CMHC Act, assuming that federal staffing grant assistance would be available to assist them in providing comprehensive mental health care) where it will be difficult if not impossible to provide services without further federal assistance. To date, only 58 of the 128 agencies which received Federal construction grants but no staffing assistance are actually operating a program, and a review indicates most of these 38 are part of a hospital. If the remaining 90 buildings are to house comprehensive community mental health centers, funds to support these programs must come from either the federal government or the

[1] The Relative Impact of Various Factors, Including Community Mental Health Centers, in the development of Mental Health Resources, Report of a Study of a Decade of Change in Mental Health Needs and Resources in Four Counties, Using Base-Line Data Obtained as a part of the Study of Community Resources in Mental Health, Made by the Joint Commission on Mental Illness and Health, Completed in 1960, submitted by National Study Service to NIMH pursuant to Contract No. HSM-42-70-108.

states. Yet there seems little likelihood that the states will pick up all of these costs, for reasons stated above.

We hope that later this year, the subcommittee will take a careful look at the CMHC program and find some solution which will enable existing centers to continue their highly effective and essential work, and at the same time enable those communities awaiting the establishment of a CMHC to receive the services they need.

Thank you for this opportunity to testify.

ATTACHMENT 1

APPROVED-UNFUNDED FEDERAL GRANTS FOR INITIATION OF NEW CMHC'S

Pikes Peak Family Counseling & MHC, Colorado Springs, Colo	$817,658
Southwest Denver MH Services, Denver, Colo	334,454
Leon County MHC,[1] Tallahassee, Fla	500,000
Kalihi-Palama CMHC,[1] Honolulu, Hawaii	309,741
Snake River Comp. CMHC,[1] Boise, Idaho	613,397
Region Ten Comp. MHC, Columbus, Ind	557,362
Regional Mental Health Center, Kokomo, Ind	500,000
Johnson Co. Southwest CMHC, Overland Park, Kans	215,385
Barren River Comp. Care Center,[1] Glasgow, Ky	741,913
Washtenaw County CMHC, Ann Arbor, Mich	511,890
West Central Montana Reg. Comp. MHC, Anaconda, Mont	250,250
North Central Montana Comp. CMHC, Great Falls, Mont	722,076
Las Vegas Mental Health Center, Las Vegas, Nev	894,771
Northern New Hampshire MH System,[1] Littleton, N.H	349,367
Christ Hospital CMHC,[1] Jersey City, N.J	526,794
Monmouth Medical CMHC,[1] Long Branch, N.J	488,194
Queens Hospital CMHC, Jamaica, Queen, N.Y	1,071,274
Northeast CMHC of Memphis Shelby City, Memphis, Tenn	374,796
Murray-Jordan-Toole Mental Hygiene Center, Murary, Utah	484,756
Champlain Valley MHC,[1] Burlington, Vt	622,310
Valley Comp. CHMC,[1] Morgantown, W. Va	277,391
Humacao CMHC,[1] Humacao, Puerto Rico	569,883
East Oakland CMHC, Oakland, Calif	1,088,726
Thalians CMHC of Cedars-Sinai, Los Angeles, Calif	1,492,480
San Jose CMHC,[1] San Jose, Calif	92,816
Emanuel Hospital CMHC,[1] Turlock, Calif	85,684
Jefferson County MHC. Lakewood, Colo	226,062
Southern New Castle MHC.[1] New Castle, Del	267,913
St. Joseph's CMHC,[1] Tampa, Fla	1,406,460
Palm Beach County Comp. CMHC,[1] West Palm Beach, Fla	576,571
Northside Hospital Comp. CMHC, Atlanta, Ga	325,865
MHC of St. Joseph County, South Bend, Ind	265,212
Southern Bluegrass Comp. Care Center,[1] Danville, Ky	421,876
Western Kentucky Region I CMHC,[1] Paducah, Ky	741,913
Acadiana MHC, Lafayette, La	647,949
Montgomery General Hospital CMHC, Olney, Md	746,193
Erich Lindemann CMHC,[1] Boston, Mass	1,192,626
Philadelphia Psychiatric Center,[1] Philadelphia, Pa	386,992
Mayaguez CMHC,[1] Mayaguez, Puerto Rico	399,224
Tufts Mental Health Center,[1] Boston, Mass	331,348
Greater Lynn CMHC Program,[1] Lynn, Mass	1,142,997
South Central Montana Reg. MHC,[1] Billings, Mont	126,349
Community Center for Mental Health, Dumont, N.J	572,998
Rutgers CMHC, New Brunswick, N.J	1,993,502
Brookdale Hospital CMHC,[1] Brooklyn, N.Y	1,031,999
Buffalo General Hospital CMHC, Buffalo, N.Y	950,855
Orange County MHC,[2] Goshen, N.Y	880,268
Wilson Green Mental Health Center,[1] Wilson, N.C	500,000
Carl Albert CMHC,[1] McAlester, Okla	817,853
Holy Spirit Hospital CMHC, Camp Hill, Pa	811,054
Hamot CMHC, Erie, Pa	624,994

[1] Indicates poverty.

ATTACHMENT 1—Continued

APPROVED-UNFUNDED FEDERAL GRANTS FOR INITIATION OF NEW CMHC'S—continued

Meadville City Hospital CMHC,[1] Meadville, Pa	$443, 270
Albert Einstein CMHC. Philadelphia, Pa	567, 587
Austin-Travis County MH/MR Center, Austin, Tex	712, 963
Bell County MH/MR Center,[1] Belton, Tex	786, 947
Harris County MH/MRC, Houston, Tex	119, 983
Southwest Mental Health Center, Columbus, Ohio	625, 475

CHILDREN'S SERVICES

Greater Little Rock CMHC, Little Rock, Ark	146, 350
John Hale Health Foundation, San Francisco, Calif	241, 040
Wheeler Clinic, Plainville, Conn	642, 984
The Counseling Center, Bangor, Maine	438, 755
Massachusetts MHC, Boston, Mass	382, 683
Columbia Area Mental Health Center, Columbia, S.C	404, 025
Dallas County MH/MR Center, Dallas, Tex	785, 051
Open Harbor, Inc., Boston, Mass	59, 000
Tufts Mental Health Center,[1] Boston, Mass	268, 532
Cambridge-Somerville MH/RC,[1] Cambridge, Mass	127, 163
Emerson Hospital, Concord, Mass	150, 640

INITIATION & DEVELOPMENT

[All poverty areas]

Alabama Catchment Area M-16C, Mobile, Ala	45, 148
Community MH/MR Center, Lawrenceburg, Ind	49, 720
MH Association of North Central Massachusetts, Fitchburg, Mass	50, 000
Cape Ann Children & Family Center, Gloucester, Mass	49, 956
CMHC Area 43, Hudson County, Newark, N.J	50, 000
Riverview Hospital, Red Bank, N.J	48, 650
Rio Del Norte Planning Committee, Espanola, N. Mex	49, 990
Clinton Co. MH Services, Plattsburgh, N.Y	50, 000
Franklin County MH/MR Board, Columbus, Ohio	36, 472
Board of Co. Commissioners Multnomah Co., Portland, Oreg	47, 404

ATTACHMENT 2

CMHC STAFFING GRANT APPLICATIONS PENDING WHEN APPROVAL PROCESS CUT OFF BY HEW

Ozark Guidance Center, Box 515, Springdale, Ark	
Tucson East CMHC, 36 North Tucson Blvd., Tucson, Ariz	$300, 000
San Jose CMHC, 77 North 15th St., San Jose, Calif	85, 684
Westside CMHC, 2201 Sutter St., San Francisco, Calif	300, 000
Bayview CMHC, 101 Grove St., San Francisco, Calif	241, 040
Central City CMHC. 4272 South Broadway, Los Angeles, Calif	2, 610, 750
Sacramento Co., MH Services (North), 2315 Stockton Blvd., Sacramento Calif	238, 378
Resthaven Psychiatric Hospital, CMHC, 765 West College St., Los Angeles, Calif	250, 021
East Los Angeles Health Task Force, Los Angeles, Calif	
Sunset, Richmond Oceanview, San Francisco, Calif	1, 739, 879
Sacramento County, MH Services (East), Sacramento, Calif	179, 636
Peoples Clinic, Santa Ana, Calif	199, 757
Comp. Mental Health Services, of East Central Indiana, Inc., Muncie, Ind	
Silver Spring Takoma Park, 7600 Carroll Ave., Takoma, Md	
Regional MH Complex, P.O. Box 43, Starkville, Miss	303, 399
Pine Belt Reg. MH & Retardation Complex, Suite 406, Carter Bldg., P.O. Box 161, Hattiesburg, Miss	
St. Francis Hosp. CMHC, Gordenville & Mount Auburn Rd., Cape Girardeau, Mo	
Southeast Jackson Co. CMHC, Lees Summitt, Mo	

[1] Indicates poverty.

ATTACHMENT 2—Continued

CMHC STAFFING GRANT APPLICATIONS PENDING WHEN APPROVAL PROCESS CUT OFF BY HEW—continued

Thousand Hills CMHC, Kirksville, Mo	
Lutheran Mental Health Center, 415 South 25th Ave., Omaha, Nebr. (Mervin Riepe, Administrator)	
Lincoln-Lancaster MHC, 1107 Lincoln Benefit Life Bldg., Lincoln, Nebr	
North Platte Psychiatric Clinic (Great Plains Mental Health Center), 221 South Jeffers St., North Platte, Nebr	
St. Joseph's Hospital CMHC, 2305 South 10th St., Omaha, Nebr	
Mid-Nebraska CMHC, 916 Baumann Dr., Grand Island, Nebr	
Southern Nevada CMHC, Las Vegas, Nev	
Washoe Co. Center, Nev	
So. Comp. CMHC, Nevada	$894, 771
Community Ctr. for MH Inc., 2 Park Ave., Dumont, N.J	
Gloucester Co. MHC, Psychiatric Clinic for Gloucester Co., Tatum St., Woodbury, N.J	
Mercy Hospital of Watertown, 218 Stone St., Watertown, N.Y	
Marymount Hospital MHC, 12300 McCracken Rd., Cleveland, Ohio	1, 563, 517
Child & Adult MHC, 1009 Realty Bldg., Youngstown, Ohio	1, 505, 699
Southwest CMHC, Columbus, Ohio	3, 038, 742
North Central Hamilton Co., Inc., Cincinnati, Ohio	2, 895, 210
S.E. Cleveland CMHC, Cleveland, Ohio	9, 796, 783
Concerned Citizens CMHC, Toledo, Ohio	3, 962, 215
S.W. Pittsburgh CMHC, 2005 Sarah St., Pittsburgh, Pa	
Northeast CMHC, Roosevelt Blvd. & Adams Ave., Philadelphia, Pa	
Hall-Mercer CMHC, 8th and Locust Sts., Philadelphia, Pa	
Child Guidance Center, West Philadelphia Consortium, 1700 Bainbridge St., Philadelphia, Pa	
City-County Clinic, P.O. Box 669, Johnston, Pa	
Divine Providence CMHC, 1100 Gramplan Blvd., Williamsport, Pa	
Episcopal Hospital, CMHC, Front St., and Lehigh Ave., Philadelphia, Pa	
Centerville Clinic, Inc., R.D. No. 1, Fredericktown, Pa	
Central Montgomery MH/MR Center, 1100 Powell St., Norristown, Pa.	
St. Francis General Hospital, 45th St., Pittsburgh, Pa	
Central Pennsylvania CMH/MRC, Day Care Center, Pennsylvania	140, 780
Cambria County CMHC, Johnstown, Pa	
MH/MR Center for Hidalgo County, P.O. Drawer 1108, 1425 South 9th Edinsburg, Tex	
Bear River Mental Health Center, County Courthouse, Bringham City, Utah	
Windham County MH, 67 Main St., Brattleboro, Vt	
Windsor County MH, Hospital Professional Bldg., P.O. Box 6, Springfield, Vt	533, 115
Falls Church-Fairfax County, 4100 Chain Bridge Rd., Fairfax, Va	
MH Service of Roanoke Valley, Carlton Terrace Bldg., Suite 500, 920 South Jefferson St., Roanoke, Va	
Department of MH & Hospital, P.O. Box 40, Salvada, Va	
Fairfax South City, 4080 Chain Bridge Road, Fairfax, Va	
N. Panhandle CMHC, 2000 Eoss St., Wheeling, W. Va	
Allegany County Health Department, Willow Brook Rd., P.O. Box 690, Cumberland, Md	

NC CMHC National Council of Community Mental Health Centers

TO: NCCMHC MEMBERS MARCH 20, 1973

GENERAL REVENUE SHARING FUNDS
USE BY CMHC's

Generel revenue sharing funds heve been ellocated for community mental health center programs by some locel governments, although on e national basis CMHC's have not been abla to obtain any significant revenues from thie source. This fact is emerging from the Nationel Council's survey of members regarding the use of General Revenue Sharing Funds. (All responsas are not yet in, a full summary will be sent to you es soon as it is eveilabla).

Local and state governments heve now received revenue sharing ellocations for 1972 and for the first quarter of 1973. Between now and July 1, many etates and localities will be making finel decisions on the usa of these funds during the coming fiscel year (1973). It is important for centers to make strong efforts to tap these resources since:

- Many states and localitias will have eurpluses during this fiscal yeer es e result of unexpected general revenue sharing federal dollars;
- Programs funded this yeer under revenue shering will probably find it aasier to obtain similar funding in the future (general revenue sharing funds are now authorized for five yeers).

Eligibility

Centers are aligible to receive funding from both state and local governments under the new proposad reguletions published in tha Federel Register, February 22, 1973. The only restriction pleced on the usa of general revenue sharing funds for community mental heelth centers is that,

Revenue sharing may not be used to provide the etate or local matching required under any federel cetegoricel grant program (this would apply to staffing, alcohol and drug abuse staffing grants, children services staffing grants, etc).

Use of Funds by CMHC's

All other program operations of community mental health centers can be funded from General Revenue Sharing under the law. To date, centers report using (or planning to use if expected or hoped for funds actually become available) such funds for:

- *Basic operational costs, overhead etc.
- *Program expansion
- *New staff not provided for under federal grant in order to provide expanded outpatient services, etc.
- *Community-based outreach programs
- *Drug and alcohol programs
- *Various programs previously supported under Title IV-A Social Services funding
- *Travel expenses
- *Staff development
- *Capital outlays

Note: General revenue sharing is still a potential source of funds for programs previously supported through Titles I, IV-A and IV-B, X, XI, and XVI of the Social Security Act.

Indirect Assistance through Revenue Sharing

Revenue Sharing can also be an indirect help for centers in securing local revenue. The availability of revenue sharing dollars has, for instance, freed other local money for one community mental health center. Without revenue sharing funds or an increase in local taxes this center would probably not have been able to obtain requested local funding, although the funds received did not come directly from revenue sharing.

Some cities have also used revenue sharing funds to free local tax dollars, which they have then spent in areas where revenue sharing funds cannot be used (such as matching federal grants). This is a bookkeeping device which enables the locality to transfer its own funds from one program to another. For instance, it is possible for local funds used for operating costs to be replaced by revenue sharing dollars while the local tax money is used to match a federal grant. However, although such devices have been used in some localities (but not by Community Mental Health Centers) the legality of such acts are now being tested in court.

Localities to Date better source of Funds for CMHC's than States

From a preliminary analysis of the NCCMHC survey, it appears that local governments are a better potential source of revenue sharing funds for CMHC's than are state governments. Thirteen centers receiving support indicated that the funds came via the local government, no centers reported revenue sharing funds via state governments. However, this could result from:

- State governments being slower to allocate these funds as the legislators must first act to appropriate the money;
- The fact that states received less funding under the General Revenue Sharing Act than did localities;
- Most centers concentrating their efforts at the local level (according to our survey this seems to be the case).

Making Contacts re. Revenue Sharing

It is clear from our survey that many centers have not been as vigorous in their pursuit of these funds as have others. A large majority have contacted only their state or local government, not both. Those working at the state level have usually contacted one agency -- the mental health agency. In order to maximize your chances of receiving these funds you should consider contacting:

- State mental health agency
- State public welfare department
- Govenor's office
- state legislators
- Other departments, if any, with responsibility for social programs or rehabilitation services, including alcohol and drug abuse if not covered by mh agency.

Other Issues

One problem for centers looking for general revenue sharing assistance is the widespread ignorance of the law and its provisions among state and particularly local government officials. Copies of the federal regulations may be obtained from NCCMHC if you are having trouble persuading your local or state agencies

that your programs are eligible. It is also important for you to find out:

- *What funds are available
- *When allocation will be made
- *How the governments plan to decide on use of funds (any opportunity for public participation?)

At the beginning of each entitlement period, each governmental unit must file with the Treasury Department a report on how revenue sharing funds will be spent. Such reports must be made publicly available under the law.

The next payment of general revenue sharing funds to states and localities is planned for April 6, 1973. There is still time to tap these funds for your center.

Chris Koyanagi
Staff Associate

Jonas V. Morris
Executive Director

TERMINATION OF FEDERAL CMHC PROGRAM --

THE EFFECTS OF THIS POLICY AT THE LOCAL LEVEL

ARIZONA

Camelback Hospital Mental Health Center
Scottsdale

Our Center is preparing to handle the termination by raducing the services provided for in-patient and partial hospitalization and concentrating on out-patient and community education and consultation activitias. We are working together with the Arizona Council of Community Mental Health Centers to develop a unified department of mental health, bringing together the community programs of tha State Health Department with the State Hospital as well as alcoholism and drug abuse programs. Hopefully this will allow us to develop contractual relations with other state agencies. This will change our funding basa from grants to contracts and we will be reimbursed after tha services have been provided. To move into this method of providing sarvices it will be necessary for us to project a budget based on anticipated provision of sarvices which will be done after a thorough assessment of the catchment area using demographic material to indicate what persons might be sligibla for the services for which we can be reimbursed by the State.

Regarding the way in which the administration's cutbacks will affect us, in all probability we will terminate all in-patient hospitalization. In past years this has meant approximately 20 patients per year and 450 patient days. Partial hospitalization will cause a loss of service to another 25 patients per year and 250 patient days. Fewer free community education programs will be provided and greater reliance upon contractual consultation relationships for which we are reimbursed.

Finally, our Board is being forced to become involved in extansive fund-raising activities. As yet, we don't know how successful thesa will be.

CALIFORNIA

Gateway Hospital CMHC
Los Angeles

Gataways Federal staffing grant provides approximately $76,000 per year at the 30% funding level. Loss of these monies would have an adverse affect on our budget.

Currently, we have 18 positions which are funded by the CMHC staffing grant; 13 full time and 5 one-half time. We budget $233,000 for these positions and the Federal grant returns $76,000 to us. It is likely that with the loss of Federal monias, we would have to tarminate a number of thase positions.

COLORADO

City and County of Denver
Denver

We do not yet know whether Federal revenue will be replaced by state or local funds. However, there appear to be two possible sources of funds to replace the Federal Share of our grant. The first is revenue sharing money which could come to us from the City and County of Denver. To get this money, we would, as you know, have to compete with other health agencies of the City and County since there are no revenue sharing monies specifically allocated for Mental Health. To date, however, all revenue sharing monies received by the City have been allocated for capital improvements, not Mental Health. Whether we would get these monies is problematic.

The second possible replacement for the NIMH monies is the State of Colorado's Division of Mental Health. At the present time the State picks up most of the costs of the grant using the following formula: Total eligible costs of the grant minus the NIMH share (now 30%) equals the State's share of the grant. We are not yet clear on what happens when the NIMH share is zero percent; it could be that the State will consider its obligation to the grant ended when NIMH considers its obligation ended, or it could be that the State will be required to pick up 90% of the total eligible costs (all but the ten percent local share). This issue is currently being debated in the State Legislature.

If money is not forthcoming from either revenue sharing or the State of Colorado, we would have to curtail services and lay off the staff provided by our federal grant which expires at the end of FY 1973. Staff involved would be four of the seven nurses in our psychiatric emergency room, the Directors of Psychiatric Rehabilitation and Psychiatric Training, and several members of our inpatient and outpatient teams.

The loss of this grant would wreak havoc on our emergency room, our training program, and several other teams.

FLORIDA

District Mental Health Board No. 4
Tallahassee

The number of persons served by this clinic has grown from 1,651 per year to approximately 2,158. Eighty-five percent of these families are medically indigent and cannot afford $35 to $40 a visit to a psychiatrist in private practice. These families are too numerous to be cared for as charity cases by local private mental health practitioners. Moreover, the demand for services is still sharply increasing. In addition to Leon County, the Leon County Mental Health Guidance Center has expanded its services into seven counties: Franklin, Gadsden, Jefferson, Liberty, Madison, Taylor and Wakulla. Five counties, Gadsden, Liberty, Madison, Taylor and Wakulla provide funds appropriated by their county commissions for general mental health services. In addition, five other counties, Franklin, Jefferson, Liberty, Madison and Taylor support school psychological services provided by the clinic through appropriations and contracts with their school boards.

All of these services to the rural population in our District are undergirded by a traveling team which consists of a psychiatrist and a mental health nurse visiting the five other counties participating with county commission funds. The psychiatrist and nurse evaluate and treat patients while providing expert consultation to local physicians and community agencies who also serve these same patients and their families.

Supplementing this psychiatric team is another mental health professional (usually a psychiatric social worker) who works with patients on an average of once a week and consults with community agencies. Most of the funds which have been supporting the psychiatrist, nurse and social worker in helping patients are Federal dollars under Titles IV-A and XVI of the Social Security Act. Unfortunately, these funds have been diverted into revenue sharing so that they will no longer be available to support these needed services. Many worthy programs cut off from Federal funding are approaching local units of government for additional monies which their governments do not have. Thus, we anticipate that we shall have to curtail these needed services, unless local and state governments can totally support them, which seems unlikely.

An additional blow to our plans to provide mental health services to our District was the lack of funding for new National Institute of Mental Health Staffing Grants. We had such a $500,000.00 grant approved but not funded as a result of the federal cut-backs. This grant was to fund four satellite clinics strategically located throughout the district. Needless to say, these counties, given their meager tax base, cannot support such an expansion.

But the question can be asked: Are these services effective? The answer is an emphatic "yes". Take Leon County, for instance. In 1965-66 the rate per 100,000 population for admissions to the State Mental Hospitals was 153.0. During 1970-71 it was 17.5 or a drop of 43%. That is, 43% more patients were being treated in the community on an outpatient basis. They did not have to leave their families or their jobs, or schools, depending on age. Thus, these services are preventive in nature, and hence less costly. This sharp reduction in State Hospital admissions is even more dramatic when you consider that from 1960 to 1970 Leon County population increased by 39%. If national statistics hold true, and we have reason to believe that they do, then one person in ten needs mental health services, making this reduction in the need for hospitalization even more dramatic. It is anticipated that, if the traveling team could remain in effect strengthened by satellite clinics, a similar reduction in state hospital admissions rates could be made in the other seven counties.

There is another area where Federal funding benefited the emotionally disturbed in our District and that was the implementation of the Baker Act. The Baker Act got the medically indigent mentally ill out of jail, where they used to be kept until they were admitted to the State Hospital, and into a local hospital where they could be treated. Now, this money will have to come from state and local sources, because of Federal budget cut-backs. Moreover, Title IV-A and XVI funds were used to help persons who were potential Baker Act cases, but for the present needed only out-patient care.

The number of drug abusers is hard to estimate because our I & D Grant was not funded but some dimension of this problem may be appreciated since there are, in addition to the 200,000 population, 24,464 students enrolled in Florida State University, Florida A & M University and Tallahassee Community College, who present a high risk category for drug abuse. We also served the Black community

in Tallahassee through Information and Referral Center and a free medical diagnostic clinic for persons who were substance dependent. The funds for this program have been cut off. Needless to say, the Black Community is very upset, since this was a prevention program and several well established organizations strongly favored it. This program was to be the rallying point for more comprehensive programs in Drug Abuse, but with the loss of this program we have lost credibility with the Black Community to the point where they probably won't support further grants.

If our alcoholism programs are eliminated, 558 public inebriates will be directly adversely affected out of a total alcoholic population of 4,613 according to the Jellinek formula. This program provides a sixteen bed half-way house, a fifteen bed sub-acute detoxification center or "sobering-up" station and outpatient counseling and psychiatric services.

An important component of our NIMH staffing grant were services to high risk families. There is no private Family Service Association in our District. Traditionally, our agency has filled this gap. With the loss of federal funding, it is inevitable that this service too will be effected.

It is difficult to gage the impact of this loss of service on families. Half of our caseload of 2,950 involves children and adolescents and their families. The community need is expressed by 980 divorces in our district in 1970.

IDAHO

Department of Health
Boise

The new policy of no new starts of community mental health centers directly affect two of Idaho's seven catchment areas. One area has planned and received word of NIMH approval of the plan without funding. A second area has an initiation and development team in operation and we're nearly prepared to submit a grant request to staff a comprehensive community mental health center.

It is the case that about 2/7 of Idaho will not be served by comprehensive community mental health services. All of these counties have the state hospital programs available to them for serious problems of mental illness. The elements that are lacking are intermediate, emergency and consultation and education services. Idaho has been able to initiate crisis intervention kinds of outpatient services through small centers but there remains a large unanswered number of problems in these two areas.

The severity of the unanswered problems vary. We have data from other areas that at minimum, one hundred people with serious mental disabilities and illness will go unserved in each region. As many as eight times that number would use the service if they could afford them or if they were made available.

ILLINOIS

Ravenswood CMHC
Chicago

At this crucial time when there is an increasing national awarensss of ths need for comprehensive services for mental hsalth programs such as CMHC'c which were designsd in a way that they would be located right in the community and would be visible and accessible to all community rssidents for s broad rangs of servicss would suffer. For examplo, ths Ravenswood CMHC during its ons and one-hslf year sxistence has successfully curtailed the uss of stats hospitals and othsr institutional care for the residents in this community.

It is ironic that the President's rationals for suggesting a cutback for funding in CMHC's is based on their success and their sxpected capability to survive on local funds and revenuss generated from eervices. It has to be smphasized that this goal of self-support is a worthy one, but taking into consideration that ths majority of clients using thess services are the working-class poor and the low-income family groups and the lack of sxisting national hsalth insurance or adsquate psychiatric coverage in the existing third-party carriers precludes ths generation of any substantial revenues.

INDIANA

Regional Mental Health Center
Kokomo

I belisve ths mental hsalth movement has come full cycls: from smphasis on domicilisry care in lsrge institutions far removed from ths familiar to concsrn for the place where prevention begins and treatment snds - the community. Virtually a century and a quarter of humanitarian progress and significant lsgislation in the development of positive mental hsalth programs is being jeopardized at present. The evolution of community mental health is viewed as a highly positive and emergsnt concept in social policy planning, directing rssponsibls citizsn action towards community-based sfforts to promote mental health.

Fortunately, the Kokomo Regional Mental Health Centsr has the very active support snd backing of vigorous unions in the area. Fortunately, ths labor unions have negotiatsd for msdical coverage with thsir employsrs which provides reimbursement for the complete range of psychiatric services available at ths Regional Mental Health Center. Fortunately, we have been abls to sxist on sxisting sources of rsvenus from counties, the state as a dsficit financer, patisnt fess, contributions, etc. Ssdly, our existsnce is a very marginal ons in terms of sffsctivsness due to having to operate on a shoe string budget without any fedsrsl monisa.

We do have a Federal Staffing Grant that has been approved but unfunded. If we had federal support, we could be dslivering sxtensive mental health services to our thres county area. As it stands, our outpatient staff, for sxample, which consists of two geographic tsams have one tsam with two psychologists and ons social worksr sndesvoring to deliver esrvicss to Howard County (excluding Kokomo),

Tipton County, and Clinton County. Theoretically, at least, this team delivers all outpatient, consultation and education, and emergency services to this very large area consisting of approximately 100,000 people. Realistically, we are not visible to the community, very tangible, or very useful. Realistically, we cannot mount satellite clinics, staff them, provide active partial hospitalization programs, do the necessary consultation and education work with existing institutions, agencies, and caretakers that would be community-enhancing.

Realistically, none of the promises set forth in the community mental health model will be attained at this rate. Worse yet, this mental health center is in relatively good shape, all things considered. We are, at least, alive, if not well. Indiana's plan calls for 32 centers to be built, funded, staffed, etc. There are six. There are significant questions as to just how the six will continue, let alone 32. This, in short, is the impact of Mr. Nixon's somewhat less than enlightened policies relative to community mental health centers.

MISSISSIPPI

James L. Robinson (Law offices of
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Greenville

From 1967 until 1971, I was chairman of the commission which has developed the Community Mental Health Centers program in the Greenville area. Although I now have no official connection with the program, needless to say I have remained keenly interested in the progress made. I am very much afraid that, if new appropriations are not made, not only will the many hours of work which I did in connection with our local program go for naught, but I strongly suspect that many other centers around the country will go down the drain.

The inescapable fact is that, if federal support for the Community Mental Health Centers program is withdrawn, it will not be replaced by support from state or local sources.

Here in the Greenville area we began our program in 1967. We now have a staff of more than 20 persons serving a four county area. The construction of our main center in Greenville and our branch center in Cleveland is well under way. In short, we are on the verge of realizing the dreams of many people who have worked many hours without pay, and frequently without thanks. Based on my knowledge of the finances of the program, I greatly fear that much of this will come to an abrupt halt if federal funds are withdrawn. Likewise, I have every reason to believe that there are many other communities and regions not only in Mississippi but throughout the nation that are in a similar situation.

No knowledgeable person questions the need for controlling federal expenditures. By the same token, I think any knowledgeable person will have to admit that the Community Mental Health Centers program has been a tremendous success and that this success could have not been accomplished without federal support. In addition, I think any knowledgeable local observer would also tell you that, had we had revenue sharing for the past ten years, we would not, at least in Mississippi, have seen anything like the progress that has been made in the Community Mental Health Centers program.

Delta Mental Health and Retardation Program
for the Fifth Region of Mississippi
Greenville

Here in Mississippi we have only half of the number of centers which were planned for according to state plan operating at the present time. There are three other regions or catchment areas which either have already submitted or plan to submit in the near future staffing grant applications. Of course, if Congress accepts the President's recommendation, no new centers will be funded by federal monies. The community mental health center concept, I can assure you, has been well accepted in Mississippi. Regional centers are operating with a good deal of success which can be backed up by facts and figures. Personally, I am all for economizing at the federal level, but it appears to me that reducing the amount of money which is spent to subsidize community mental health center operations is false economy and only leads to increasing the actual per dollar cost to the taxpayer if mentally ill and mentally retarded individuals are allowed to go untreated.

This is NOT a give-away program. It is instead a program of prevention. Sliding scale fees are charged. Direct immediate savings to the state and local governments are visible. The Boards of Supervisors of Washington, Bolivar and Sharkey counties have been solidly behind this Program from its inception, and as you know, they are astute businessmen. Advisory Councils made up of doctors, lawyers, agency representatives, ministers, civic leaders and others are consulted. We have all seen it work.

The Delta Mental Health and Retardation Program is comparatively new, but there are already over 1700 client folders in the files, and more than 150 clients are seen each month. Services offered include psychological and psychiatric evaluation and counseling, medicine checks, marriage counseling, behavior programs, services for the retarded, inpatient care in local hospitals, a 24-hour emergency service, and consultation and education. The area of consultation and education includes working closely with schools, law-enforcement, state agencies, Youth Court, etc., making professional help available to them at a local level.

These statistics cannot of necessity reflect cases such as (1) a father who is a productive, responsible citizen, but who, without these services, available early and close to home, would have been a patient at the state hospital, with emotional problems much harder or impossible to cure. This would have meant state assistance at the overworked hospital, long-term local and state financial aid for his family, and loss to his employer, not to speak of the loss to the man himself. Or (2) a young girl, formerly angry at the world, her parents and herself, in trouble with a law-enforcement agency, who is now in college and well on her way to being a contributing citizen. She would probably have been a real drain on public resources. Or (3) an older woman who without regular medicine checks would of necessity have to live permanently at a state institution.

Every dollar spent in establishing these services prevents the expenditure of many more dollars by individuals, local, state and national governments - by moving people from welfare into taxpayer status, prevention of crimes and suicides, families kept together, prevention of the development of chronic mental illness, enabling many "mental patients" to remain in society as parents and employees, and providing local professional help to existing agencies. Even if you leave out the humanitarian aspect, it makes much more sense economically.

MONTANA

Mental Health Clinic
Great Falls

Our grant application has been in process for three years, received a regional review in September, 1972, and was given final approval at N.I.M.H. in December, 1972. The starting date was to have been January 1, 1973.

The geographical area is in northcentral Montana and includes ten counties (Glacier, Toole, Liberty, Hill, Blaine, Pondera, Chouteau, Teton, Judith Basin, and Cascade.) All are participating counties with the exception of Chouteau, which is presently making quite positive consideration. The area is 25,952 square miles. The smallest county is larger in area than Rhode Island, and Chouteau is about half the size of Massachusetts. I mention these areas because there is a definite relationship to mental health services. About 147,000 people are living in these ten counties. Three Indian reservations are located in Glacier, Hill,and Blaine Counties. The general area is that of an upside down triangle, with Great Falls as the apex. Many of the towns located on the "base" line or Hi-line, as we call it, are 100 miles or more away, which definitely deprives people of services.

The only mental health professionals in the whole area are located in Great Falls, with the exception of one professional on the Indian reservation in Glacier County. Two psychiatrists and one and one-half psychologists in private practice in Great Falls are trying to serve a geographical area larger than ours, and about 200,000 people. They say they are essentially doing emergency service. The state Mental Health Clinic located in Great Falls is staffed with two and one-half professionals who are doing mostly emergency work with a backlog of about nine months. There is no encouragement by the staff for any type of "greater business." We are already completely overwhelmed. Most of the agencies -- schools, welfare, courts, Indian reservations, county health nurses, alcoholic treatment units, etc. -- most often do not refer because they have learned there is much too long of a wait for any services. The Indians on the three reservations essentially get no service from the clinic.

Probably because there are no mental health professionals in schools in our ten counties, in the past,63 percent of our referrals have been school-age children, with a wide variety of problems. Most often work is done with the parents, often complete evaluation of the whole problem. About five percent or less of our cases are what could be termed mentally ill.

Our proposed program is set up to first begin to meet the tremendously large general mental health needs in our area, which are presently so definitely being unmet by the sprinkling of both private and public mental health professionals.

The three Indian reservations are essentially unserved, and there are plans to place professionals on the reservations for a full range of services. The Indians have been closely consulted, and their definite request was for the placement of personnel on the reservations. Almost any indices is higher among the Indians -- alcoholism, suicide, school dropouts, broken homes, etc. Presently, if hospitalization is needed for Indians, the state hospital is more than 300 miles away. There are plans to establish major satellite units in Havre and Cut Bank. Four or five smaller units will be placed in other locations around the ten counties. Essentially, we wish to make general mental health services available and easily accessible.

Presently, it is often necessary to travel more than 100 miles for mental health services to Great Falls, incur the expenses, and take a day off from work. Often people do not have cars and public transportation is practically nil.

There are little to no services in the area for senior citizens, emotional and child development for parents, alcohol and drug addiction, manpower aid (psychological factors in not getting or retaining jobs), vocational rehabilitation evaluations, evaluation and therapy of problems with junior high, high school, and college-age people, and marital therapy. There is no inpatient capability and practically no real immediate emergency service available.

Our consultation and education capability is very thin and small. We would augment consultation considerably if we became a comprehensive center. Planned is consultation to V.I.S.T.A., C.A.P. (Indian), alcohol and drug units, clergy who have requested aid, juvenile courts in connection with law infractions, manpower planning, private physicians requesting services for their patients, schools, welfare, Head Start, Follow Through, and the usual agencies requesting consultative services.

There are no alternative mental health services, as there often are in urban areas. There are no family service association units or other services people could turn to outside of the few extremely overworked private people located in Great Falls.

We felt the Federal Government was particularly farsighted in setting up community mental health centers in rural areas and poverty areas such as ours because of the total lack of alternative services. It was a way of finally obtaining basic mental health services. With non-renewal of the Mental Health Act, an area such as ours has little hope of getting services from any other source.

NEVADA

Southern Nevada Comprehensive Mental Health Center
Las Vegas

Our proposed staffing grant would have resulted in an expansion of our current Mental Health Center Program. It was not for a new Center. Therefore, the effects on us will be in terms of our being unable to expand needed services. The proposed grant would have roughly doubled our current staff of sixty (60) and would have enabled us to provide beefed-up services in all areas but, especially in our black community, Westside, in which we currently have a very small Satelite Clinic. We had proposed a staff of twenty-one (21) for that clinic, whereas currently we are operating with two full time equivalents. The answer as to how many people must go without care as a result of the cutoff of federal dollars can only be a very rough approximation. The population of the Westside area is in the neighborhood of 30,000 and clearly a staff of twenty-one can much more adequately serve the needs of that target population than can a staff of two. Overall, we serve two catchment areas with a combined population of over 300,000. We will be unable to provide any new services to these people.

In terms of funding, our Clinic is almost totally funded by State appropriations with a very small fraction coming from collections. Staff increases are totally dependent on State appropriations. The way it looks at this point, we will be

authorized only two new positions for the next two ysars, a social worker and a mental health technician, both to be assignsd to the Westside Satelite Clinic. In summary then, the overall effect of the unfunded staffing grant situation is that we will maintain pretty much of a status quo in ths community.

Due to ths fact that our legislature is currently in session and due for adjournment within thirty (30) days, and also, since they only meet bi-annually, a succssful effort to get ths Community Mental Health Centers Act renewed this year would have littls impact on us until 1975. At that time, the lsgislature would have the opportunity to approve appropriations of State funds for matching, if they saw fit. So in terms of our own local situation, it appears that for us, ths ball game is over.

NEW JERSEY.

Five Mental Health Centsrs in the State of New Jersey have rscsived final approval from ths Federal Govsrnment in terms of receiving Federal staffing funds. Two other Nsw Jsrsey centers received approval for Initiation and Development funding prior to their developing a Mental Health Centsr. The first five Centsrs are:

The Rutgers Community Mental Health Center, Piscataway
Ths Monmouth Medical Center, Long Branch
The Christ Hospital Community Mental Health Center, Jersey City
The Gloucester County Mental Health Centsr, Woodbury
Ths Community Center for Mental Health, Dumont

The two Centers for ths Initiation and Devslopment Grant ars:

Ths Monmouth County Riverview Hospital, Red Bank
Mount Carmel Guild Institute, Jerssy City

In terms of population that these 7 facilities would have ssrviced, we are talking about 1,204,407 individuals. In terms of finances that would have flowed from the Fsdsral Government to the State of New Jersey over an 8-ysar period, we are talking about a sum of $5,500,000.

New Jersey has the unenviable distinction of having ths largest number of Community Mental Health Csnters that have received approval but will not be funded. No othsr stats in ths union is losing out in this particular area as much as the State of New Jersey.

Christ Hospital
Jersey City

We have submittsd a staffing grant application to N.I.M.H. which was approvsd several months ago, but unfortunately not fundsd.

This grant is for community mental health center which would involve a broad range of services to people in our catchment area with a population of 100,000 in the heart of Jersey City. This is an economically deprived area, designated by H.E.W. as a poverty area. The total budget of this facility would amount to approximately $750,000 annually, and would provide Inpatient, Outpatient, Partial Hospitalization, Consultation and Education, Emergency Services as well as a rehabilitation program. It has a capability of serving several thousand people a year.

There is no community mental health center in all of Hudson County and there is a vital need for this type of program. While there is a bill in the state legislature to increase the availability of mental health funds, it will not nearly meet the needs of Jersey City. At this point I do not see any possibility of getting the kind of funding that would have been available through H.E.W.

We feel that if this program is not implemented it would be a tremendous loss to the community.

NEW YORK

Community Mental Health Center
Glen Falls Hospital, Glen Falls

Warren and Washington Counties which are served by our Community Mental Health Center ranked 11th and 13th in terms of the rate of use of state hospitals, whereas, in the rate of use of local inpatient services Warren and Washington ranked 1st and 2nd. This would tend to show that a high rate of use of local facilities correlates with a low rate of use of state hospital facilities. This is one of the indices of effectiveness of our Mental Health Center.

These findings are being replicated at many other Centers. All the citizens of our country deserve these services. A number of planned Centers which had been approved are now unfunded, including five in New Jersey alone. An approved but unfunded Center in New York State particularly meriting support is that at Buffalo General Hospital.

NORTH DAKOTA

Mental Health and Retardation Center
Grand Forks

Our Center currently has federal support for a single staffing grant scheduled to expire December 31, 1974. Yearly support at the 30 per cent continuation level amounts to approximately $48,000 to $50,000. We will undoubtedly feel the effects of a discontinuation in federal funding, but it is doubtful we would be forced to close our doors immediately. Over the years we have been able to accumulate a sizable contingency reserve in anticipation of the Community Mental Health Center Act phase out. This reserve would enable us to operate up to one full year at current staffing levels.

So the immediate problem is not a lack of funding as much as it is the question of whether to utilize our contingency reserve now to adequately staff our Center only to be forced to cut back in the future, or to continue to operate under-staffed to enable us to operate for a longer period of time.

An original impetus for the Community Mental Health Center Program was the need to develop an effective alternative to the archaic public mental hospital. In North Dakota this is being accomplished. Since the inception of the centers, the population at the State Hospital in Jamestown has dropped from 2200 to 700 residents. Alternatives to long-term hospitalization are made available by the Centers to enable individuals to remain in their communities as working, taxpaying citizens. A second objective of the program is to make mental health services available to the entire population of our country. In North Dakota this too is being accomplished in that seven out of eight Centers already established serve 95% of the state's population. Another important factor to consider is that the Mental Health Centers in North Dakota have been responsible for recruiting over five times the number of psychiatrists in our state previous to the establishment of the Centers, not to mention the many other mental health professionals who currently work and reside in our fine state.

It does not seem logical that a program such as this be discontinued after having been commended by the Nixon Administration for its merits and its successes.

Future growth of our Center will be severely impaired due to the discontinuation of grants available for specialized programs for alcoholism, drug abuse, geriatrics and children's services - programs all of which are needed in our catchment area.

North Dakota can be proud of its efforts in the area of mental health. In 1969, the Mental Health Centers of our state were awarded the Gold Award (1st place) by the American Psychiatric Association for their accomplishments. North Dakota is repeatedly cited by representatives of other states in our region as being a forerunner in the delivery of mental health services.

Memorial Mental Health and Retardation Center
Mandan

Our original grant is financially significant due to the fact that we are at the upper limits of our state and local financing. In North Dakota we have seven Centers (five federally funded - two not funded are combination mental health-social services). The state, since 1966, has doubled the mental health center budget every two year session. It is a generally accepted feeling that this year's budget is the highest we will ever get out of the legislature. The increase in state funding has just about kept pace with the declining federal support. All Centers have presented mill levy resolutions to the voters in their county catchment areas. These have passed and are at the 3/4 mill maximum allowed by law. It is also felt that there would be little chance of raising the limit and having the voters approve a higher level of taxes on themselves.

Third party payers (other than patient fees, which amount to about 2%) are almost non-existant. Welfare will not pay for services as long as there is a federally supported Center in the catchment area. Other federal agencies decline to pay due to cut backs in their funds. North Dakota Blue Cross/Blue Shield has a rule that they will not pay to a salaried physician-psychiatrist such as are employed at the Centers. Thus, to receive any payment for inpatient service we must have our psychiatrists bill Blue Cross/Blue Shield on a private basis. The psychiatrist then turns the check over to the Center. Negotiations to change these attitudes and unwritten rulings have met with failure. Consequently, it appears that third party payments will never be a dependable source to replace federal funds in North Dakota.

All in all, I guess you could say that our funding is nip and tuck. The state share has increased as the federal portion decreases. Thus, what would be future matching monies for new grants, services and programs are used to match the declining federal share. Consequently, the staff on our original staffing grant which expires in FY 1973 will be terminated unless the Act is renewed and extended. Our operation would have to be curtailed as our staffing grants expire.

Recently our Center, plus several others across the nation, were subjects of a funding audit review and projection performed by the G.A.O. investigative arm of Congress. Their conclusions are the same as I've alluded to in the last several paragraphs. They informed us that the impression they came up with as they toured, was that continued federal funding at some level was needed in almost every case. They asked us if we would estimate the level of continued funding needed to maintain our present program. Our answer was two-fold; if we were funded across the board including operating expenses we could probably get along on a 30% - 50% level - staffing only 50%-70%. These lower levels would mean status quo - the upper levels would allow for some program and service expansion. As a federally designated poverty catchment area, we would hope to be on the top end of the percentages. I think you will find our position is similiar to the other North Dakota Centers. Revenue sharing doesn't seem to be much help. Our state share is being committed by the legislature to education. County shares are out because of our mill levies. City revenue sharing is very small because of the small size of our cities.

OHIO

Southwest Community Mental Health Center
Columbus

The funding available to the Southwest Center in the coming year will include the local tax levy and state matching funds; special state funding for a forensic psychiatry program; federal funds for childrens' services through a part F grant subcontract; minimal Title IVA Social Services reimbursement; fees and contributions; third-party insurance payments; and hopefully some additional state and federal money for drug programming. Of greatest concern is the collection of higher proportions of the budget in fees and third-party payments.

Due to the lack of federal funding, the following programs have not been implemented: crisis hospitalization for children and adolescents; adolescent inpatient services; adult inpatient services; and adolescent day treatment program.

The rest of our staffing grant proposal has been implemented but on a smaller scale than envisioned. This is possible through funds produced by a .75 mill tax levy supported by Franklin County voters. The Center program in Madison County is funded through a special per capita allocation from the State Department of Mental Health and Mental Retardation despite minimal local matching funds.

We are not satisfied that we are meeting the total mental health needs of catchment area residents despite our extensive efforts to involve community members such as school personnel, clergymen, and medical professionals in this responsibility. It is obvious, however, that the county cannot increase our funding. Fortunately, it is also likely that the county will continue its present level of support for our program so long as we demonstrate continued ability and desire to meet our share of the mutual contract.

The most critical issue involved here, therefore, is not the denial of

services to the residents of the Southwest Catchment Area. It is, rather, the denial of services to residents of other areas in the county. The 1970 census data places three other catchment areas in higher priority than the Southwest Area. (In 1960, Southwest was second priority area.) One of these, East Central, has a federally funded comprehensive mental health center (Columbus Area Community Mental Health Center). Program development in the other two areas is greatly hampered because local funds are tied up in the Southwest Area. Federal funding of the Southwest program would release approximately $650,000 in local and state funds which could be used to develop services in the other two areas. One of these (Southeast) has virtually no mental health services at all for a population of 81,065. North-Central, currently the highest priority area, contains Ohio State University, which provides some psychiatric services for training purposes, and Willson Children's Center, a small outpatient counseling service with a staff of eight professionals, serving a catchment area of 143,649 people. The primary mental health facility serving each of these areas is Columbus State Hospital, located in the Southwest Catchment Area.

Ohio Department of Mental Health and Mental Retardation
Columbus

Ohio has been somewhat slow in getting into the utilization of this program, primarily because the partnership of Federal, State and local governmental, and private non-profit parties was not fully operational until recent years. As a result, Mental Health Centers were slow in getting off the ground in Ohio. This leaves Ohio in the unenviable position of being a "poor" state in regards to utilization of these funds.

Now, however, an aggressive Community Mental Health program is resulting in marked declines in State hospital populations and much improved services. Therefore, we believe it is vital that this legislation be continued in order that the mentally handicapped people will be able to benefit from the improvements of services, the ability to obtain treatment at home, the opportunity to avoid the taint of institutionalization, and the other benefits of this program. Furthermore, the requirements for broad citizen participation in the program represents one of the few truly effective ways in which the consumer can voice his participation in the affairs of a health and social services agency. This is a unique factor which has not been often stressed, but which we think characterizes Community Mental Health Centers far more than most other health care services.

Two specific applications have been made in the 15th Congressional District, which are now being recommended for approval. Immediately at risk are some $3,000,000 worth of applications which have been recommended for approval. but would probably not be funded.

The Federal program has provided some $40,751,88 to supplement mental health services in Ohio. These funds in effect constitute a return to Ohio of Federal Income Taxes paid by Ohio citizens. Ohio is 45th in magnitude of shares, meaning that our tax dollars are helping 44 states above a level we are willing to help ourselves. The grossly differential funding levels not based on per capita, but rather who got there first or who was fortunate enough to have available machinery to complete the task is what is shown. We recognize that much government funding is in this competitive pattern but should not be the case for the provisions of direct services to people or for programs which are part of a long-range national strategy. If we play the game of statutes, then the haves remain haves and the have nots remain have nots. But the have nots through taxes continue to support the haves. This seems inequitable, both in terms of monies returned to a state and the quality of service provided to the people of that state.

The loss of $23,000,000 in Federal tax funds to the state of Ohio's Community Mental Health program will be very significant. It is clear that where Community Mental Health Centers have been in operation for approximately three years, there are statistically significant reductions in admissions to state mental hospitals. We feel that this is significant,especially in view of the fact that Ohio's public mental hospitals have had great difficulty coping with the enormous problems they have faced in the past few years and have provided what must be described as less than satisfactory care. On the other hand, Community Mental Health Centers prevent displacement of the person from his home, his family, often times from his employment, and provide for a variety of treatment modalities which cannot be delivered from the base of a distantly related State hospital, but must somehow be available to the patient within his own community.

PENNSYLVANIA

Community Mental Health Center
St. Francis General Hospital
Pittsburgh

Our in-patient and partial hospital services costs can be recovered from 3rd Party payers such as Blue Cross, Medicare and Medicaid, since perdiems were reduced upon receipt of the grant over six years ago. The aggregate amount now received by St. Francis CMHC from a Federal Grant totals in excess of $600,000. Whether the County Mental Health/Mental Retardation Office can assume the part of this responsibility related to outpatient, satelite, consultation and educational and evaluation services over a two year period (due to their budget year being July through June) remains to be seen. Other sources, including the St. Francis General Hospital, do not seem to be available to meet a major part of this deficit in the foreseeable future.

Episcopal Hospital CMHC
Philadelphia

Episcopal Hospital Base Service Unit is a small clinic providing limited mental health outpatient therapy (direct service staff of approximately 12 people) to a community of 150,000. The clinic is located in the Kensington area of Philadelphia. Because the need for more than "token" outpatient therapy is so apparent in the community, representatives of the community along with staff of the clinic have volunteered countless hours over the past two years to prepare and submit construction and staffing proposals for a federally funded Comprehensive Community Mental Health Center.

At the present time there is NO EMERGENCY SERVICE, NO INPATIENT FACILITY, NO PARTIAL HOSPITAL, NO CONSULTATION & EDUCATION, AND EXTREMELY LIMITED OUTPATIENT SERVICE.

This Community is on the edge of seeing its tireless efforts fulfilled. They don't understand why there may be no money for their approved proposals. They don't understand why the community will have to continue to have unnecessary crises because there will be no service.

Northeast Mental Health Center
Philadelphia

Cuts would affect the center's services to children in the following ways:

Increase need for child hospitalization
Delay identification of learning disabilities, causing delay of remediation
Increase divorce or separation rate
Increase delinquent and criminal behavior
Increase demand for placement of children
Increase behavior problems in school at expense of learning students.
Increase rate of hard core emotional and delinquency problems not amenable to treatment

Consultations and education services have already been affected in the following manner;

Schools - In May/72 we had 42 programs in 23 schools with 9 additional request for programs from other schools. Programs included: peer counselor training, parent groups, drug education, in-service training for teachers and counselors, case consultation, rap groups, behavior modification, crisis rooms, classroom observation, tutoring programs and child management courses. These services were directly and indirectly assisting a potential population of 23,000 children in the public schools of our catchment area as well as additional children in the Catholic schools. Presently, we are providing 25 programs in 12 schools, a reduction close to 50%.

Outreach - (home visits, case finding and motivating individuals for treatment) From February/72 to July/72 (6 months) 711 individual contacts were made. From August/72 to January/73 (6 months) 327 individual contacts were made, an approximate decrease of 50%.

Consultation was similarly decreased to other groups.

If Reductions Continue

- We will have to decrease or discontinue consultation to 3 housing projects with a population of 1800 individuals
- Case consultation to Community Legal Service will have to be decreased or discontinued, involving service to 70 individuals per year.
- Leadership training for over 30 percent and potential community leaders will be decreased or discontinued. This has definitive value in terms of strangthening the community
- Childrens's Agency consultation services, directly and indirectly assisting 130 to 150 children will be decreased or discontinued.
- There will be a decrease or termination of participation in community task forces to deal with various community and social problems
- Consultation to other groups will be decreased or terminated.

Northeast Philadelphia Catchment Areae

A transitional Outpatient Clinic at Philadelphia State Hospital serves approximately 400-500 ex-state hospital patients who live in catchment areas serviced by undeveloped CMHC's (Catchment Area 5B- Episcopal Hospital; Catchment Area 7B - and proposed 7C - Nazareth Hospital; lower Bucks County Catchment Area). The eervices available to theee ex-patients are eeverely limited due to lack of staff, space and funds.

The Outpatient Clinic at PSH is especially known to the community residents of catchment areae 7B and proposed 7C. Unfortunately, although it ie clearly visible and eaeily accessible the clinic is not allowed to provide services to persons who were not PSH patients. Theee two areas have had very little if no help in terms of community mental health services. This means that approximately 261,000 people have had minimal servicee or have been left to their own devicee to deal with mental illnese.

At the present time, both 7B and proposed 7C are looking for and negotiating to contract various mental health agencies to provide mental health services mandated by the Community Mental Health Centere Act. Without sufficient federal funds (as well as funds from the State and local levels), the two community boards of these catchment areae will not be able to secure adequate services for their constituents.

Philadelphia Centers

A total lose of approximately $7,863,078 in new Community Mental Health Center programs and new drug and alcohol programs for the uncovered catchment areas can be expected as a result of the new federal fiscal policies.

The lose of new mental health programs for children cannot accurately be estimated because most of the plans had only recently begun. One catchment area, planned to initiate a comprehensive children's program that wae budgeted at $1,011,786 in total cost for fiscal year 1974 but would have required less than half that amount in federal staffing grant support. The value of three planned children's programs wae approximately two million, of which about $800,000 would have been eligible for reimbursement through federal etaffing grants.

The effect of the federal budget for 1974 on the proposed new alcoholism and drug abuse programs remains to be calculated since federal eupport for new programs is budgeted in "formula" grants to the states. However, the amounts appropriated for fiscal year 1974, - $30 million for alcoholism programs $15 million for drug abuse programs, and $40 million for drug abuse prevention and treatment programs (under the general direction of the Special Action Office for Drug Abuse Prevention) will clearly be inadequate to enable the Centers in Philadelphia to comply with the federal requirements to develop these programs.

One of the most alarming waye in which existing Community Mental Health Centers are affected by the federal phase-out is in the consequent necessity to increase the kind of services which are reimbursed by health insurance programs as a means of replacing the reducing federal contribution through staffing grants. This economic restraint seriously undermines the prime purpose of Centers to intervene at an early point and to prevent disability since it rewarded treatment of exisitng disorders. The consultation and Education Services, are particularly hampered by thie trend, since by and large, third party payments are not available to support this function.

Additionally, the original principle that community mental health programs should be available to all people regardless of their personal income will be gravely impaired by policies favoring those who are either sufficiently poor to qualify for Medical Assistance, or sufficiently well off to buy commercial health insurance plans.

VERMONT

Windham County Mental Health Service
Vermont

Windham County Mental Health and Windsor County Mental Health submitted on February 1, 1973 a joint Staffing Grant application which culminated two and one-half years of work. This application was developed at a grass roots level involving the establishment of Task Forces on the local level to determine the unmet social needs of our total population. There were Task Forces on the Problems of the Aging, on Alcohol Abuse, on Drug Abuse, on Problems of Youth, on Mental Retardation, on Developmentally Disabled including Epilepsy and Cerebral Palsy and on the Problems of Low Income Vermonters. All of these task forces were established based on the understanding that if a comprehensive service delivery system could be developed on the local level it would be supported by a Mental Health Staffing Grant.

The fact that Bennington and Rutland have received such a grant and provide comprehensive mental health services is a very visible contrast to the lack of similar services in Windham County.

WASHINGTON

Comprehensive MHC of Tacoma-Pierce County
Tacoma

At the time our eight year staffing grant runs its course, we will be receiving approximately $215,000 in Federal funding, which would then be lost. That represents approximately thirty-three percent of our budget. Although the State is moving to increase its appropriation for community mental health (the budget is about doubled and the priority will be given to reducing state hospital admissions) the total amount of non-Federal funds which will be available at that time will not make up for the loss of Federal funds. It's difficult to predict, but I would guess that we may expect to have approximately half of the loss covered.

That is the budget for our present program; we are just opening a childrens services program and expanding services into a rural portion of our catchment area which has not been previously served. We are also affiliated with the local Council on Alcoholism which is a developing program and we are a member of an alliance of drug abuse agencies which is trying to develop a comprehensive program for this County. All of those efforts would be very severely effected by loss of Federal funding because our resources would have to be diverted to make up that loss. We would not be able to continue expanding our services to meet well documented local needs.

Strangely enough, one of the effects of this anticipated cutback may well be to increase the amount of indirect service that we provide. This may be in contrast to what you are hearing from many centers, but if I have to do a major service reduction I will be recommending that we shift to service strategies which have demonstrably greater impact on community mental health need. That is, we will work more closely with other organizations and support them as they deliver services rather than attempt to maintain our current level of clinical service delivery.

April, 1973

Mr. MORRIS. I would like to turn to Dr. Carver and subsequent witnesses to have them tell you briefly of their programs.

STATEMENT OF JOHN CARVER, PH. D.

Dr. CARVER. I am John Carver. I would like to spare you a blow-by-blow, detailed story of the problem in Texas. I have a statement I would offer for the record.

Mr. ROGERS. Without objection, it will be made a part of the record following your summation.

Dr. CARVER. I am glad to be back but not too glad to find a great deal of time going into whether we have done a good job with the program and whether we should or should not continue.

I suppose I should move to the next plateau and say: All right; what can we do to make the program better? I am not happy about that and will be glad to see the committee get into that part of it.

My prepared statement is highly critical, highly self-critical, of our programs.

I regard myself as somewhat of a renegade in the field, with great love for it. I served as chairman of the National Council of Community Health Centers, as you are aware. Maybe I am the loudest spokesman about change within the system mainly because I believe—and perhaps this is a statement of what community mental health has to offer—I believe self-criticism is the most healthy thing that can happen with it. I say that because very often my statements are taken as lack of support, and I don't want that interpreted that way.

I am totally in favor of the continued Federal role, primarily because I see the system having developed at this point to the phase at which this subcommittee and the counterpart in the Senate can get hold of what is happening within community mental health and make it much, much better than what it already is.

I see a loss of that role if Congress is stripped out of its policy-making position with regard to community mental health centers, nature of service, the nature of what we deliver once we get there.

The State of Texas Department of Mental Health and Mental Retardation reaffirmed its support that it will not let community health centers currently existing die. However, it is not yet to the place where it can provide the impetus for new starts in the way the Federal role could do.

National health insurance, even if it becomes available with funding for mental health coverage, introduces as many problems as it does solutions, as has been discussed by Dr. Roy. Funding systems, either with no service system or inadequate service system or antiquated system—which the community health system will be in a number of years if we don't continue to update it—will cause a rise in prospects.

As Dr. Brown said, the danger to services is great. This is the most fruitful area in terms of prevention, and long-term numbers of service units per dollar is the part that gets cut first when we have budget shortages.

This subcommittee went on record in favor of getting a special thrust into the indirect services. Those are the parts that will be cut first should we shift to just the fee for service funding.

As I remember, Mr. Nelsen, you introduced that into the committee.

It is time for further action by Congress to continue updating what we are doing in mental health centers, and I look forward to our turning our full interest to that.

Mr. ROGERS. May I interrupt for a second? I apologize, but I have a commitment I must go to right now. I think what we will try to do is get further testimony and questioning on the record with Dr. Roy and Mr. Nelsen. Then we will come back at 2 to answer further questions and to hear the rest of the witnesses.

Dr. CARVER. Would you like us to continue?

Mr. ROY [presiding]. Yes.

Dr. CARVER. My role in Houston, Harris County, as director of Harris County Mental Health and Mental Retardation, is a legal, separate entity from county government, but both are operated by the same persons. I have been there several months, and the things I have gotten into are management overhaul, totally redesigning the lines of management control, as we see what should be done in the programs, and redefining the mandate of mental health in Harris County.

We spend a lot of time working with other public agencies—probation, child abuse, other private agencies such as family service. there are hundreds of agencies serving mental health or mental-health-related kinds of needs in Harris County, Tex., almost 2 million population. The role of mental health in that community is spread around so you can't nail it down to any one agency.

We have seen our role as not only providing services with our Federal money and other sources of income but as helping pull together a network of human services within Harris County which would perhaps serve our future world where services are scattered about, people don't know what each other is doing, and even public money goes into a total scatter in a gap system.

Mr. ROY. Can you do that without discouraging some of the efforts of voluntary organizations? In other words, doesn't their effort to centralize somewhat dampen some of the voluntarism which has been useful although not coordinated?

Dr. CARVER. We have not found that to be the case. It may be because of the manner of centralizing; that is, we do a whole lot of involving people in the process. Going ahead and planning, if you don't plan to actually do, you get in a quagmire of input and nothing happens.

Inviting community criticism of what we have done—this is a strange process we are trying out, and voluntarism has not suffered.

In redesigning our program, our service delivery, this is the beginning throughout our service units; we have two community health units in our 10 catchments. In redesigning our program, we are looking very hard at the kinds of things mental health says it is trying to do but has not gotten around to doing. That is the great area of unmet need where the usual excuses are too little money and too little manpower. They are not good excuses, and we have a long way to go in redesigning our service system.

We are redesigning several things. We redesign what the professional role is in the delivery of services.

Mr. ROY. Let me interrupt again. Are you getting good physician participation in the efforts you are making?

Dr. CARVER. As a matter of fact, I hired a new psychiatrist just for helping us work through some of the difficulties of this in addition to persons on the staff.

Mr. ROY. Are you getting cooperation from physicians other than psychiatrists, from other organized groups in Harris County?

Dr. CARVER. This is yet to be seen. It may be an area of difficulty and it may not.

I will end my comments rather quickly. I know we are pressed for time.

I would like to work in the area of health concepts as training concepts. We have isolation where we don't have facilities for training. We need training for mental health professionals and other related fields, people doing the mental health work, the clergy, schools, public health nurses, welfare workers, and a great number of persons who do more mental health work than all our centers can ever do. Perhaps it is of a different nature, but there is no excuse for not making resources available to make those skills available throughout the country. That is the only way we will get the prevention.

I will stop because of time.

[Mr. Carver's prepared statement follows:]

STATEMENT OF JOHN CARVER, PH. D., EXECUTIVE DIRECTOR, MENTAL HEALTH AND MENTAL RETARDATION AUTHORITY OF HARRIS COUNTY; HOUSTON, TEX.

Mr. Chairman, members of the Subcommittee, I am John Carver. My academic training is in business administration, economics, education and clinical psychology. I am a past Chairman of the National Council of Community Mental Health Centers; I am employed as Executive Director of the Mental Health and Mental Retardation Authority of Harris County in Houston, Texas. My Board of Trustees is the County Commissioners' Court and the service area over which I have responsibility includes ten federally defined catchment areas serving the almost 2,000,000 people of Harris County, Texas.

Our programs relate in some way to almost all facets of human services from health clinics to child welfare to drug abuse to special education. We have a growing use of paraprofessional manpower and an abiding commitment that program overhaul and reconceptualization are needed far more than additional money to make our services make sense.

Inasmuch as this Subcommittee has interest in the qualifications of those who serve in mental health centers, I will limit this prepared statement to a few comments about reconceptualization as it relates to that topic. My remarks are intended to represent no one's views but my own.

We have gotten ourselves into quite a bind with reference to qualifications in this field. Various myths have cluttered our thinking and sometimes fattened our budgets: high academic training is necessary to be a good therapist; mental health is a medical matter; paraprofessionals are second-best servers to be used with the poor; a community's mental health work is done by the mental health professionals. On these myths and more we have based much of our mental health establishment. They are highly suspect.

Qualifications are important. But we have too often looked at the wrong ones. We make the mistake even now of assuming that the higher the academic degree, the greater is a person's credentials for helping others. There is no research support for that. Vested interest support, however, abounds, particularly in psychiatry, clinical psychology and clinical social work. In fact, we would be quite hard pressed to show you that a psychiatrist, as an example, can produce any better psychotherapy results than can a carefully selected, trained layman.

Unfortunately, we discuss standards and quality as if our professional biases were not involved. And we often end up with "quality" defined as providing any given service with the most overtrained, expensive person available. It is striking how pompous we can become about quality of care in a system which by its own admission misses at least 93% of the problem area. The unmistakably professional air to our irrelevance serves to protect us from the pain of missing 13 out of 14 seriously disturbed youth (Joint Commission on Mental Health of

Children Report; even with a grain of salt, this statistic has impact). You don't repair that kind of failure rate by adding more money, neither do you swallow the hogwash that we cannot do more because of our manpower shortage. We truly have much to learn about the use of what we already have.

There is a critical role for professionals, but that role is to pass on to others the skills and insights which they possess. Off-staff this training function should be worked out with schools, public health nurses, physicians, parents, clergy and others so that our communities and the people who affect them shall have maximal access to the practical details of developing healthy children and adults and of dealing with the troubled. After all, these are the people seeing 14/14 of those disturbed kids, not 1/14 as are we. But the real payoff is that these are the people whose contact with the total population puts them in a unique position to prevent emotional disorder, criminal behavior and the myriad other problems of emotional growth. The economics of this approach are obvious.

Intramurally in the management of the more direct mental health services, we must make greater use of academically lesser trained therapists for two main reasons. The first is the need to reach more persons in pain for the same dollar. Experience shows this certainly can be done. The second reason is in the long run more important. We must model a belief that the therapeutic function is primarily a human helping relationship, not the medically modeled function of Dr. Shrink acting upon a "patient". This calls upon us to believe in people more than we have so far. For we can never begin to approach the mentally healthy community so long as mental health is a territory held by the experts, carefully protected by the guilds of our trade. Psychiatry may be the worst offender in this regard, but I can assure you that my own discipline, were it on top of the pecking order, would be no different.

Already these factors have led centers to greater use of paraprofessionals, but often in menial roles or, on the other hand, in responsible roles not adequately backed-up. There are a number of instances where a good balance has been struck, but the amount of mental health dollars so spent make up a small proportion of the whole. Where the idea has worked best, I suspect you will find a professional staff which is not only competent but, more important, personally secure. To bring about growth and effectiveness in others calls for growth and effectiveness in the teacher. We must remember persons become mental health professionals by academic achievement, not by being mentally healthy. Consequently, our ability as persons to help others grow (with the exception of techniques and concepts) may be no better than anyone else. Watching how the pros problem-solve in staff meetings and how we deal with each other in our personal lives will illustrate my point.

The techniques and concepts are what we have to offer; they can be taught, someone taught them to us. Ideally, our direct service centers would have a small core of professionals who could also personally live this quality we call mental health. We would have a much larger staff of therapists or counselors whose academic level would be irrelevant. They would be chosen on the qualities of being sensitive, intelligent, eager to learn and to grow themselves and would have tasted enough life to help others.

Direct counseling would be done by these people (the term "paraprofessional" I would intentionally drop) with adequate training and careful supervision done by the high cost staff. The expensive staff would also be giving a considerable and increasing amount of time to extramural programs to enrich the emotional growth skills of teachers, clergy and the host of others. Primary prevention through these others would be programmed to become more and more the raison d'etre of the center.

Almost no direct therapy would be performed by the high cost staff except as a co-therapy training experience for a minister from the community, a staff counselor, a school guidance counselor or other person whose skills could grow through such an exposure. But let us use only the professionals who bring out the growth in people for this task; not every clinician is good at this. Bitter pill though it may be, there is some obligation for publicly supported mental health programs to employ professionals who are personally effective and insightful, whose heads—as well as diplomas—are "together".

The field of mental health, due in large part to community mental health legislation, has come face to face with a dilemma of future shock. Multiple social problems are increasingly seen in mental health terms: drug addiction and abuse, child abuse, crime and delinquency, rehabilitation, alcoholism, broken homes, education, the problems of aging, of early childhood development and of mental

retardation, not to mention turmoil in the streets. And the Congress on several occasions has asked community mental health centers to reach out more broadly (witness the areas of aging, alcoholism, drug abuse in addition to re-emphasizing services to children and state hospital patients). Properly examining what mental health is all about would certainly find the above list to be relevant. Indeed, we have a tiger by the tail.

To speak of really serving all these needs—or any one of them—with the operating style we now employ makes hollow rhetoric of our buzzword "comprehensive" and a farce of this Subcommittee's hopes. Thirteen out of fourteen is a difficult statistic to square with our rhetoric. And when we hear claims that the Community Mental Health Centers Program has achieved comprehensive mental health coverage for 50,000,000 Americans, one wonders just which of the other claims are equally meaningless.

While the Congress is itself no stranger to rhetoric, it has on the other hand been able to cut through to reality on enough occasions to give us hope. Much depends on you as you ponder future legislation and funding patterns. For the path of our services follows the available dollar far more than reason, research and rhetoric combined would have it go.

But despite my own evangelism for change and despite the organizational and guildism trickery we are heir to, the optimistic fact is that community mental health has the verve and self-criticism to lead in its own revitalization. The faith and good fortune I have personally enjoyed from my colleagues testify to the acceptance of even sharp criticism.

But our desire to change and improve continually must be aided by those who set the guidelines. Help us make it better. Do not ask us to quote last year's client figures, ask what new ways have been tried to reach the persons we did not see. Ask not how many psychiatric beds we need, but how many we can cause to go empty. When we quote those frightening statistics on mental disturbance, ask us not to forget them as soon as we start designing our programs. You see, we seem to remember the size of the problem only while asking for more money. Help by setting the financial contingencies in authorizing legislation so that there is payoff for moving in progressive directions.

In fact, this Subcommittee led the way in 1970 when it wrote the Mental Health Consultation Grants amendment into P.L. 91–211. That was the only Congressional move until that time or since designed specifically to influence the *mode* of service delivery (cutting across all service *targets* such as children or other groups). Lack of funding left it ineffectual, but the precedent was set. The Amendments of 1970 made a statement of Congressional approval of the special nature and potential of the indirect services (training, consultation, back-up). Due in part to this affirmation by the Congress, we now hear much of the notion to fund the indirect services separately when pervasive insurance coverage someday provides revenue for the direct services.

We need very much to have the financial rewards clearly in line with the public good. They are not now and the advent of National Health Insurance, should emotional disorder coverage be included, threatens to make the situation worse by enticing us back into more regressive forms of service. No one can set these matters in order but the U.S. Congress and the Community Mental Health Centers Program must be responsible to take it from there.

Mr. Roy. Ordinarily, I think, we would take your statements successively but, because we may get a quorum call at any time, I will ask Mr. Nelsen if he has any questions.

Mr. Nelsen. Not at this time.

STATEMENT OF ELMER EDIGER

Mr. Ediger. I am Elmer Ediger from Newton, Kans., near Wichita. Because part of the context for this hearing related to questions of internal administration, I am trying to represent somewhat the internal experience of administration and, by way of further background, I have been administrator, executive director of the center for 15 years and with 10 years of previous experience.

I come to the field of administration not via the mental health professions but via the field of management in general.

Our center is actually somewhat different from many other centers, and this is, in part, necessary to give this background so you can appreciate what I am saying. We are a nonprofit center which existed long before the Federal mental health legislation came along. We have a psychiatric facility, not a mental health center, with a hospital and some outpatient services.

Then later we took on the responsibility of three counties as a catchment area on a contract basis, so that we have in our program a catchment program, and this extends more widely, much like a voluntary general hospital would serve a wider territory.

Our staff consists of 4 full-time psychiatrists, 6 psychologists, 12 social workers, and a total of about 110.

Since becoming a community health center, we have focused strongly on the matter of the chronically mentally ill, those who have been in the State hospital before. We have built a close working relationship with the State hospital but, more important, we have developed alternatives to the hospital situation in the local community so we have reduced hospital stay and admissions to the State hospital to among the lowest in the State.

We have no State financial support with which to do this. We have up to a half-mill local levy, so you see we are very much limited. It is about a dollar per capita. So really what has enabled us to develop this type of comprehensive program with all these alternatives has literally been the Federal Staffing Act moneys.

With regard to our administrative pattern internally, there are several things which we feel are important. In our case, we believe that it is difficult to find in any one executive all the qualities that are needed for good management of what a mental health center represents.

A mental health center is a professional operation and also very much of a total business and management operation; so, in our case, the nonprofit board designates two people—a chief executive who is not a mental health professional, such as myself, and a medical director, who uses only a minimum of his time for actual management services. This responsibility is delegated through the rest of the organization. We follow through on the same principle where we seek to build in other types of administrative leadership aside from the mental health profession.

A second thing, with regard to the administrative pattern, we have a long history really of having to be accountable, partly because as a nonprofit center we have had to pay our way, find a way of paying our way, so we have sought to develop means which are now, in part, being followed by other centers.

This has to do with an information system with regard to what happens to the professional staff person's time. We call this an event-monitoring system, in which there is a daily record and it is computerized and there is a feed-out to the person and to a supervision and periodically a summary so we can clearly assess where our time is being used. This is a very important base for management.

Third, I would like to mention the fact that we have found it necessary to develop norms of productivity for professional staff, knowing that we have to produce a certain number of direct service hours which are, in a sense, partially billable through direct patient service or consultation services.

We have an average setup. On an average, all the mental health professionals together must average 26 hours a week, roughly 22 or 23 percent. However, we negotiate the norms with each person, so some may have a norm of 20 hours and another a norm of 23 hours. This, coupled with the monitoring system, enables us to know where we are, what our services cost, and what is necessary.

On the question of what percentage of our time——

Mr. ROY. Excuse me; I am sorry.

Mr. NELSEN [continuing]. That is the second bell for a quorum call. We will be back at 2.

Mr. ROY. We will recess until 2 p.m. I apologize to you gentlemen, but we will meet at that time.

[Whereupon, at 12:20 p.m. the subcommittee recessed, to reconvene at 2 p.m. the same day.]

AFTER RECESS

[The subcommittee reconvened at 2:15 p.m., Hon. Paul G. Rogers (chairman) presiding.]

Mr. ROGERS. The subcommittee will come to order.

We will continue our hearings on oversight on the community mental health centers program. We were in the midst of a panel presentation and we have concluded with two of the witnesses and have two more statements from the panel.

Mr. EDIGER. In effect, what I was saying is: As community mental health centers are becoming more mature, they are learning methods of accountability. I was trying to illustrate in our own center what, in particular, we are doing in that regard.

In another center—for example, Johnson County, which Congressman Roy represents—the center has a sort of goal with 50 percent being direct services to patient, 25 percent other services, and 25 percent administration, patient, and other.

That gives you a little feel of how we are struggling with that.

I would like to make a few comments with regard to some financial problems we encounter in administration. One has to do with regard to title 19. Even though Congress passes the legislation allowing for that kind of insurance, that kind of a program to be utilized, there was often a big gap between that and what we find usable on the local level, particularly because the State plan is that which has to be in accord with it. In our case, we get only about 2 percent—even though, it is a very helpful 2 percent—of our income from title 19.

H.R. 1, last year, corrected one of the discriminations against the free-standing community mental health centers and allowed coverage for those under 21 years of age in the hospital, the inpatient side, yet we still seem to be a long way off from being able to collect on that. Again, it is a matter of Federal regulations as well as State plans that have to be modified.

The place where we probably would hurt most if we have to rely mainly on third-party payments, including national insurance, is with regard to those types of services which are most like public health services, where there is the pursuit that is involved of the patient, the going-after in terms of education of the community, developing means of reaching the various high-risk groups.

Right now, we are hurting very badly for lack of funds for alco-

holism. There is a big push from the State level. They have money to promote it, but we have no money to carry out services unless we go for a staffing grant for services if that were available.

On alcohol, aging, schools, we do not have staffing support. At the point where that runs out, we will be hard pressed as to how we carry on that type of program.

Finally, I would like to underscore what I think Congressman Roy was saying before, that we have realized, through the Staffing Act, that this has greatly changed our system of delivery from being a hospital, an outpatient program, to a program which really works toward health maintenance, keeping people out of hospitals, but, even more than that, keeping them well. This is one of the things which I feel a national health insurance program does not as yet recognize.

Mr. ROGERS. Thank you for an excellent statement.

STATEMENT OF DR. HERBERT DIAMOND

Dr. DIAMOND. Mr. Chairman, I am Dr. Herbert Diamond, medical director of the West Philadelphia Community Mental Health Consortium and assistant director of the division of community psychiatry of the University of Pennsylvania School of Medicine.

I would like to describe our center and comment on some of the high points of our current thrust in developing a different kind of delivery model in West Philadelphia. The West Philadelphia Consortium is one of the largest and most diversified community mental health centers in Pennsylvania. It is an affiliation of six hospitals, educational and some other planning institutions of the University of Pennsylvania, the Community and Child Guidance Clinic and the Elwyn Institute, a nationally known institution in mental retardation. The name "Consortium" was selected for these multiple cooperative affiliations.

We have a program including five mandated services, a program for alcoholism, a narcotics rehabilitation program, children's services, a rehabilitation service for former hospital patients, an emergency home visiting team, a day care program for mentally retarded children, a workshop alcohol program for adults and, last week, moved a rehabilitation center to a new facility which will allow us to develop a major rehabilitation program.

We have tried to augment service capabilities and maximize dollars through linkages with existing programs and agencies of known competence.

I would like to comment on that a little further, on the emphasis we are placing on affiliation. We are currently involved, for instance, in trying to develop an affiliation with the Philadelphia State Hospital so as to relate some of their expertise in the community around problems that involve the kind of chronic patient who might at some point possibly be transferred to the State hospital.

Another affiliation that we have been enjoying is one which involves the Philadelphia College of Podiatry. The dean of the college had been interested for some time in developing a modern podiatrist who can fit in with the modern health care team and, for several years now, we have had the senior class on field placements within the agency in

some special programs. Not only do they get to see the community health system and see how we deliver services but they also have a chance to evaluate and respond to some of the podiatric needs of chronic psychotic patients and particularly one of our large programs for older adults. These patient problems are identified and referred down to the college, where they, in fact, receive direct care. This is another piece built into the system through affiliation without additional cost to the community health center.

The services that we are now developing involve considerable numbers of patients. I won't at this point go into specific numbers but comment that the service demands that are currently presented to our clinical staff require a range of skills. Although I know what psychiatrists can do, I also know what kinds of areas that we don't have skills to respond to, so we have a range of skills represented by professionally trained social workers, psychiatrists, many of whom are part time, a number of bachelor degree social workers whom we train ourselves, psychologists, registered nurses, licensed practical nurses, pharmacists, and a large group of paraprofessionals.

I would like to point out our enthusiastic commitment to this team approach of mental health care. The skills acquired extend beyond the competence of any one health field, and we recognize that and have moved actively to recruit the range of professionals that I have just mentioned to you.

Such a model takes advantage of, utilizes, and meshes a range of required skills from a number of relevant professional fields and paraprofessional experience.

I would like to comment on the fact that our emergency service, 24-hour emergency service, has really been built around an impressive staff of psychiatric corpsmen who receive their training in the Navy. We have an emergency mobile home visiting team that is currently based around the skills of a paraprofessional who has been specifically trained in crisis intervention.

This model, too, we were actively pursuing. Paraprofessionals make a tremendous contribution to us, and they are specifically trained for their basic roles.

We are actively involved in community outreach, but we are very, very sensitive about the kind of staff activities that go on in the community, and we monitor such outreach very, very closely, limiting it to areas appropriate for mental health and areas where we feel we have some competence.

Another high point, that I will end with, is one we have recently become very much involved in, and this has to do with needs for increased management skills throughout the agency. Last year we purchased a program course of instruction from the American Management Association and have been using this very effectively with all our senior staff—as a matter of fact, through all staff in the organization who have supervisory responsibilities. We have done this in our interest in increasing managerial competence throughout the agency.

In summary, I would like to review that the current thrust of our individual center at the present time is focused on the further decentralization of services, getting services out in the community, building a range of services into our outreach neighborhood facilities, affiliating with other local mental health or mental retardation related

agencies, active pursuit of the mental health team approach, and improving our management skills so we can facilitate more effective service, data collection, and fiscal accountability.

Mr. ROGERS. Thank you very much, Dr. Diamond, Mr. Preyer.

Mr. PREYER. How widespread are the crisis prevention teams in the mental health centers? Are they fairly common among mental health centers?

Dr. DIAMOND. That is one of the five basic services—that emergency service.

Mr. PREYER. Is that broad enough to cover the marital and domestic disputes to which police are often ineffectively called?

Dr. DIAMOND. I think to relate to that kind of problem, we do that through consultation with police departments.

Mr. EDIGER. I think urban centers are more organized in terms of district teams than are crisis intervention teams, usually paraprofessional teams that go out along with police calls. We have our staff on standby by telephone but, in addition to that, we have developed a voluntary crew that involves the chaplains of the community who are under our direction who, in different types of crises, are available to the police and who go out. This way we don't rely entirely on our own staff.

Mr. PREYER. I just want to thank the gentleman for an excellent statement, and I am sorry I missed the earlier part this morning.

Mr. ROGERS. Mr. Hastings.

Mr. HASTINGS. Thank you, Mr. Chairman. I also apologize for not hearing your statements this morning. I have tried briefly to read them. Dr. Diamond, how old is your program?

Dr. DIAMOND. Six and a half years.

Mr. HASTINGS. You are just about at the end of your Federal funding?

Dr. DIAMOND. Yes, shortly.

Mr. HASTINGS. What money is provided by the State?

Dr. DIAMOND. The State picks up 90 percent of the balance. We are at a 30 percent Federal level, and there is 90 percent of the balance by the State, 10 percent by the city. At this point, we don't know what the State will decide about the 30 percent.

Mr. HASTINGS. The actions of the administration do not affect your mental health centers?

Dr. DIAMOND. Not in the next year.

Mr. HASTINGS. Not at all. I understand they will honor all their obligations. That is what they testified. Your concern, I am sure, is the same as ours—to start new community mental health centers throughout the country, we must continue the Federal obligation?

Dr. DIAMOND. Absolutely.

Mr. HASTINGS. The rural areas—can you tell me, any one of you, the breakdown as to the number of community mental health centers in the urban areas as opposed to the rural areas, in numbers?

Mr. MORRIS. I don't have those statistics offhand. I can get them for you. I think it is probably somewhere around half and half.

[The following information was received for the record:]

Two hundred and three federally-funded centers serve one or more rural counties (out of a total of approximately 500 federally-funded CMHC's); this represents approximately 30 percent of all rural counties in the United States.

Mr. EDIGER. I think less than half are rural.

Mr. HASTINGS. That is my understanding. Is there a way we can make community mental health centers more effective in rural areas?

Mr. EDIGER. I think we have one center in our State, High Plains Mental Health Center, which serves practically one-fourth of the geographical area of the State.

Mr. HASTINGS. What State?

Mr. EDIGER. Kansas. It is the more sparsely settled counties it serves. For example, they will have a staff member assigned to a particular county, and this person, whatever it is, will make a weekly or monthly trip to that county seat. While there, he touches base with various groups for consultation.

The other thing we have done: In that particular center, we have health education programs, where a center staff person will go into a community and work with Home Extension Service people, the other educational groups, and train them with family life education.

Mr. HASTINGS. It provides a broad range of paraprofessional services. That is difficult in a rural area.

Mr. EDIGER. Day care center does not work well in a rural center.

Mr. HASTINGS. Hopefully we are going to extend the Community Mental Health Centers Act 1 year. Then, during that time, we will look for possible changes. Will you have recommended changes you will make to the subcommittee?

Mr. MORRIS. Yes; I referred to some in my testimony. We will have detailed recommendations at the time the subcommittee wants them. Some do go to the problems confronting rural areas. We find in rural areas the operational costs are generally much higher than in urban areas. The nonstaffing cost is larger because of the transportation, long-distance phones, additional facilities required on a few-days-a-week basis. These are things to be looked at more closely.

Mr. HASTINGS. I have a continued interest in these. I don't have any in my district. We had one at one time that didn't work out. That does not lessen or dampen my enthusiasm.

You talked, Dr. Diamond, about involvement in the community. There has been some complaint that some programs have been overly zealous, like OEO, who come in on this. Do you find much of that?

Dr. DIAMOND. We are clear the outreach programs in our center, the community organizational staff, that they limit their activities to areas relevant to mental health. We don't feel we have competence or relevance to many areas of social unrest and political action.

Mr. HASTINGS. Some people say that is a good direction for mental health to get involved throughout the country. Is it very prevalent throughout the country—that type of involvement?

Mr. MORRIS. We did a survey of some of the members on the National Council of Community Mental Health Centers on this issue, and I will be glad to submit a brief report we have.

Mr. HASTINGS. That is like having a rabbit watch over a lettuce patch, isn't it?

Mr. MORRIS. Perhaps. We did come up with some conclusions. Briefly. they are these: This type of activity was perhaps more prevalent in the early days of the program than it is currently because the program was to develop more structure and the needs for this type of activity are perhaps not as great as they were once.

This sort of activity results from, in part, the community boards perhaps seeing the need for some sort of stimulus in this area. The community boards in many cases are the ones that run the programs. There are community education programs connected with many of the centers, and these were often perhaps part of the type of activity that you are talking about.

Then there is a category of individuals associated with many community mental health centers who are referred to as the community mental health workers or organizers, who have some role in this area.

The numbers of centers involved, we found out, in any form of social action work is not high, at least according to our preliminary survey. This requires much more in-depth study to arrive at any significant conclusion. Those principally involved are in poverty areas needing this type of activity.

A small part of the social workers in the past have become involved in an adversary role rather than being involved in a catalyst role as part of other action groups. Undertaking this role, it is generally by default. There are no other social activities in the area and, if the center failed to act, no action would be taken.

Such actions have happened in urban poverty areas. Where this action has happened, it is related to mental health. No center has beome involved in community unrest.

[The social action survey referred to follows:]

SOCIAL ACTION IN COMMUNITY MENTAL HEALTH CENTERS

(The following was prepared from material gathered during telephone interviews with Directors of several poverty centers)

Community mental health centers have been mandated to establish "community participation" in their programs. As a result, the concept of a community board with programmatic and/or fiscal control was pioneered by among others, community mental health centers attempting to achieve consumer-oriented mental health service systems.

The centers also are mandated to establish new partnerships with service providers in the community and with schools, courts, probation departments and other agencies, and are encouraged to work with business and private organizations to strengthen prevention and early diagnosis of mental illness and/or retardation.

These requirements inevitably involve all CMHC's in some form of social action work. The degree to which the center involves itself in the community and collaborates with other agencies and works to improve referral practices and the awareness in other non-mental health professional personnel in the community mental health problems depends upon the center and the situation in the catchment area. Where there is a void of social service agencies and where there are actions that the CMHC can take which would improve the mental health of its clients, some poverty centers in urban areas have undertaken a larger role in improving their client's living conditions which impinge on their mental health.

These mandates are an important aspect of the comprehensive community mental health center concept. When put into practice, however, they begin to raise for some questions about the role of mental health centers, and the definition of "mental health services", the extent to which a CMHC should emphasize prevention and consultation efforts as opposed to the more traditional medical model which emphasizes direct treatment services.

In the early days of the program (mid-1960's), in a political climate which stimulated such activity, several innercity poverty area centers became involved in programs designed to reach into the community to identify social problems affecting the mental health of the community or groups in the community. This resulted in large measure from a lack of clear policy from the federal government. Since those early days, however, most centers have found themselves utilizing all their resources to meet the mental health problems in the community,

and instances of true social action (in the sense of "social reform") appear to be rare.

Social action work in a broader sense—i.e. work designed to improve mental health services and the responsiveness of the community to its needs—is being initiated in many centers. This action comes from three different sources: the community board of the center, the CMHC's community education program, and the work of outreach "community organizers".

(a) Community Board

Community boards with representatives of various community organizations, power groups, agencies, etc. set up policies and priorities for a number of community mental health centers. These priorities can result in new program thrusts, changing emphases in the program (such as initiation of new programs in certain areas: drug abuse, alcoholism, mr, training programs, etc.) which may have a profound effect on the delivery of mental health services in the community.

(b) Community Education Programs

Centers use different techniques for educating the community about mental health services, mental health issues and prevention. The community board itself often fulfills a part of this function. In addition, CMHC workers in the community play an important role, and the coordination of efforts of CMHC's and other agencies is perhaps one of the most important forms of education on mental health.

(c) Community Organizers

Community organizers are the closest thing most centers have to a "social action" arm. Generally, community organizers are trained social workers who perform the outreach work of the center (sometimes MSW's work with trained community people, "mental health workers"). Their role is to strengthen the community's awareness of services, to ensure that the center provides services to meet the community's needs (as defined by that community). They provide a feed back to the center on the feelings and problems in the community, and at the same time educate the community as to services and aspirations of the CMHC. Strengthening the community's capacity to mobilize its own resources, or identifying existing community groups which are initiating social action is also a part of the function of community organizers in many CMHC's. Collaboration between agencies, groups and individuals is often carried out through community organizers who ensure for example that back up social services are provided through the welfare department to those clients in need or entitled to such services, while mental health services are provided by the CMHC.

The social action role of the community organizer is most often that of a professional resource. Thus, community organizers have in some instances worked with existing tenant organizations regarding poor housing conditions by providing the professional corroboration as to the effects of these conditions on the health of the occupants.

While community organizers do become involved peripherally in the setting up of community organizations they rarely act directly, but provide information, some of which would be available to the community were the residents less disadvantaged. In a few cases, center personnel have been involved in the establishment of a tenent association which protested housing conditions, or other groups in the community planning to undertake a social action role.

SUMMARY

The number of centers involved in any form of social action work is not high. Those involved are principally urban poverty area centers which feel the need for this type of activity. A small proportion of centers doing social action work are, or have in the past, become involved in an advocacy role, rather than acting strictly as an educator or a catalyst to support action by other groups.

However, where centers have undertaken this role it is by default—i.e. there are no other social agencies in the entire catchment area, if the center failed to act, no action could be taken; such activities have occurred generally in urban poverty centers; where this role has been undertaken, centers' actions are related to mental health—no community mental health center has become involved in political activities, nor in stimulating any form of social unrest.

Mr. HASTINGS. One other question. HEW testified there are 35 State legislatures working on, I assume, supplying more funding to community mental health centers. Have you any information where these legislatures are at the moment, how many you expect to act?

Mr. MORRIS. No, we don't have this information. We can try to gather it for the committee if it would be useful. The only thing we have is something we submitted for the record; that is a report from various community health centers that will be losing their continuation grants in the next several years or are not going to get staffing grants they once hoped they would get, because of the staffing practice on the part of the administration.

These reports indicate they are having a hard time finding alternative sources of funding. To what extent they have gone to the legislature and tried to stimulate a constructive program for that State, I don't know.

Mr. HASTINGS. I think it would be extremely helpful to this subcommittee in subsequent considerations to have that information available. I would think your national organization would be the best possible place to get that information.

Mr. MORRIS. We will try to get it.

[The following information was received for the record:]

STATES WITH COMMUNITY MENTAL HEALTH CENTERS ACTS AS OF SPRING 1973

State:	*Date of original enactment*
Arkansas	1967
California	1957
Connecticut	1955
Colorado	1963
Florida	1970
Idaho	1965
Illinois	1961
Indiana	1955
Kentucky	1964
Louisiana	1964
Maine	1959
Maryland	1966
Massachusetts	1966
Michigan	1963
Minnesota	1957
Montana	1967
Nevada	1965
New Hampshire	1965
New Jersey	1957
New York	1954
North Carolina	1963
North Dakota	1965
Ohio	1967
Oklahoma	1969
Oregon	1961
Pennsylvania	1966
Rhode Island	1962
South Carolina	1961
Texas	1965
Utah	1961
Vermont	1957
Virginia	1968
Washington	1967
Wisconsin	1957
Wyoming	1961

Mr. HASTINGS. Thank you, Mr. Chairman.

Mr. ROGERS. Dr. Roy.

Mr. ROY. I think most of the questions I would ask have been asked. Do you feel, any of you, that we will continue to have development of new community mental health centers after the discontinuation of the act? If so, will this be on the same level that we have seen over the last few years or less? How do you see the situation?

Mr. MORRIS. Perhaps I can respond initially. You say: After the act is continued——

Mr. ROY. Discontinued, if indeed it is. If we follow the administration's recommendations, what is your feeling versus their feeling? Or is your feeling the same as theirs—that we have established such a good thing, it will carry on of its own momentum?

Mr. MORRIS. It is clear to us, from the information we have gathered, some programs may grow into the comprehensive status without Federal support, but the number will be very limited; it will be spotty, and the resources of the Federal Government just are necessary to bring about the comprehensive programs in most cases.

I think it is clear, from the administration's testimony this morning and from earlier conversations we have had with them, that they are basing their judgment on dollars materializing; it is an act of faith they are proposing here, and there is no firm information that these dollars will develop.

Part of the problem we see also is that not so many programs will continue to develop in the comprehensive sense. We want to reach the total national coverage we were seeking, but the standardization, if I may use that word, that comes from the Federal Government's being involved in this program will no longer be there.

So what you end up with, if you do yield the stimulating authority to the States, in fact is 50 different community mental health programs that many differ dramatically from State to State.

Mr. EDIGER. In Kansas, we practically have half of the comprehensive centers we probably ought to have, and I know at least three or four areas in which it is a live issue. If we had the continued staffing act, I am certain they would be coming in, in the next year or two. Without Federal staffing act money, I can see some might add a little better arrangement with the general hospital and maybe even have a day hospital of a type, but I think there is a big difference between that and making the commitment to become a comprehensive center which is seeking to maintain people outside the hospital—in other words, the building of a new system.

I think this is where the staffing act has been such a tremendous boon and, even though there may be shortcomings to the five required services, this has been very helpful to have this kind of structure which centers have to think with to provide the alternative to the hospital situation.

Dr. DIAMOND. I don't see how we could have gotten underway and achieved what we have without the Federal input.

Mr. ROY. I want to add one thing. I think your testimony, Mr. Ediger, makes all Kansans proud of the fact you are a Kansan. I know of the job you have done in Newton, and we are extremely proud of the job done down there.

I have no further questions, Mr. Chairman.

Mr. ROGERS. Mr. Nelsen.

Mr. NELSEN. To the gentleman from Kansas, I know, in your testimony before lunch, your State was not supporting your activity. Is that true with all of the centers in Kansas?

Mr. EDIGER. Our State has permissive legislation for the counties to assess themselves up to a half-mill. Our State puts in some matching money for title 19.

Mr. NELSEN. What is title 19?

Mr. EDIGER. Medicaid. Outside of that, our State mental health dollar goes entirely to State hospitals. We want no State funding system. We have a State legislative study committee in the State legislature that is being talked about, but we don't see any additional funds for the next couple of years.

Mr. NELSEN. It seems to me the State ought to have enough interest to be putting some money into a plan or program of this kind. Most States do. I think this is a point that needs to be emphasized—that is, that the Federal Government alone can't do it if the States are not in there helping. It would seem to me the State of Kansas better get with it. I will recommend to my colleague Dr. Roy that he go back home and give them the needle.

Mr. ROY. If the gentleman will yield, if you look back over the last 20 or 30 years, Kansas has been one of the leaders as far as mental health is concerned. Although they may not be appropriating as much money as we would like, I think the record is a good one.

Mr. NELSEN. I demand equal time to rebut. Minnesota is ahead of Kansas. Thank you.

Mr. ROGERS. I might say this is one of the problems we are faced with. You see, the administration is recommending that we don't have any input and let it go strictly by whatever a State may want. The State of Kansas is obviously putting money in the State hospitals. They are supporting the State hospitals. That is not always the best way, so the local communities have to come in, encouraged by the Federal Government with a little seed money. And look at what a great result we have had.

Maybe the States don't always make the right decisions by keeping big State hospitals. Maybe it has been an encouragement for communities to have the mental health program.

Thank you.

[The following letter and attachments were received for the record:]

NATIONAL COUNCIL OF
COMMUNITY MENTAL HEALTH CENTERS, INC.,
Washington, D.C., May 18, 1973.

HON. PAUL ROGERS,
Chairman, Public Health and Environment Subcommittee,
U.S. House of Representatives,
Washington, D.C.

DEAR MR. CHAIRMAN: During the Oversight Hearings on the Community Mental Health Centers Act, May 9th, you expressed interest in the extent to which CMHC's have been able to obtain funding through general revenue sharing. At that time you requested information from HEW on centers which had actually received this funding.

Enclosed for your information is a list of the centers which reported to NCCMHC that they have received such funding, and the amount of that funding where this is known together with other comments made by the centers. As you

can see, unfortunately Revenue Sharing has not greatly increased the amount of money available to CMHC's.

Also enclosed is a copy of the full summary of the NCCMHC survey on Revenue Sharing.

We would like to request that these materials be included in the record of the Oversight Hearings.

Sincerely,

JONAS V. MORRIS,
Executive Director.

Enclosures.

GENERAL REVENUE SHARING AS POTENTIAL SOURCE OF FUNDING FOR CMHC'S

SUMMARY

General revenue sharing funds disbursed in 1972 and early 1973 have been allocated by states and local governmental units for support of 21 community mental health center programs. Another 29 centers are still hopeful that they might receive some of this funding.

On a national basis, however, revenue sharing has not contributed a significant amount to community mental health centers, despite fairly vigorous efforts by centers to tap these funds.

These facts emerge from an analysis of the National Council's survey of members regarding the use of funds distributed to states and localities under PL 92–512 (General Revenue Sharing Act).

Out of a total of approximately 290 agencies surveyed, responses were received from 220 (75.8 per cent response rate). Centers responding represent 57 per cent of all operational federally funded centers. Of these respondents, 73 per cent had contacted either their state or local government (or both) in an attempt to tap this new source of funding.

Twenty-one centers received some funding through this mechanism, twenty of them from their local government's allocation, and one via the state. In general, those centers which made contacts with more than one agency at the state level, or with both their state and local government units (in other words those that made the greatest effort) were more successful in obtaining funding.

Revenue sharing dollars will be used by these centers for a variety of purposes, from operating expenses and capital outlays to initiation of new specialized programs, and replacement of Title IV–A (Social Security Act) funds or federal staffing grants which will be terminating shortly.

The success rate for centers seeking these funds is approximately 15 per cent (i.e. 15 per cent of those contacting states and localities have actually received financial assistance through revenue sharing). Several factors appear to account for this:

A general reluctance on the part of most state and local governments to fund on-going program efforts (most general revenue sharing funds are being allocated for capital outlays and other one-shot expenditures).

Widespread use of revenue sharing funds to reduce state and local taxes or to prevent the necessity of a tax increase.

Confusion among local officials as to the eligibility of center programs for aid (see earlier memos on this subject *Centers are eligible for assistance*, although Revenue Sharing Funds Cannot be Used to Match a Federal Grant).

Competition between high priority needs and the fact that at the local level mental health often does not have a particularly high priority.

Overlapping local jurisdictional boundaries, which often means that centers serving more than one local jurisdiction have had difficulty in raising support via revenue sharing from one locality if services funded are to be offered to residents of other localities.

As information comes in to Washington as to how states and localities are spending these funds it is clear that a 15 per cent success rate for community mental health centers is fairly significant. A recent survey by the Advisory Commission on Intergovernmental Relations shows that only 24 per cent of state budget officers and 32 per cent of county officials plan to use these funds for recurring expenses. The fact that there is uncertainty as to the future of revenue sharing was cited as having an important bearing on their decisions.

The amount of support available to centers from revenue sharing sources varies widely—from $330,000 for a construction project to less than $2,000 in some instances (a full listing of the dollars contributed is not available as this information was not asked for specifically on the survey.)

Below is a full summary of the 220 responses received on use of revenue sharing funds.

CONTACTS WITH STATE AND LOCAL GOVERNMENTAL UNITS

The great majority of survey respondents (73 per cent) had contacted either their local governmental unit or a state agency in an attempt to obtain revenue sharing dollars. Over a third of the centers had contacted both their local government and one or more state agencies.

Responses on contacts made with state and local agencies breakdown as follows:

	Number of centers	Percent of respondents
Contacted local government	148	67.3
Contacted State government units	81	36.8
Contacted both State and local government	73	33.2
Failed to contact either State or local government	60	27.3
Did not respond to this question	9	4.1

Most of those centers pursuing revenue sharing funds made contact with their local government, while a much lower percentage (37 per cent) contacted state agencies or legislators. This may reflect the fact that there is more money made available to localities under general revenue sharing (two-thirds of the amount authorized goes to local governments, and one-third to the states), and also the fact that states have been slower to appropriate these funds.

CONTACTS AT THE STATE LEVEL

Almost without exception, centers pursuing state allocations of revenue sharing funds contacted the mental health department or state agency with responsibility for mental health and social services.

Most centers also concentrated their efforts on just one state agency, although a few had contacted several different agencies, the governor's office and/or state legislators.

State contacts made are shown below:

State agencies contacted:	*Number of centers making contact*
Department of MH	52
Department of Public Welfare	6
Social and Rehabilitation or Health Services	4
Human Resources	2
Department of Economic Security	1
Department of Institutions	2
Department of Community Affairs	1
Office of Fiscal Management	1
Division of Drugs and Alcohol	1
State Planning Agency	1
Other State Contacts:	
Governor's Office	3 (Gov. Council on Drugs: 1)
State legislators	4

CMHC'S RECEIVING FUNDING FROM GENERAL REVENUE SHARING

Out of a total of 220 respondents, 151 of which had attempted to tap this source of revenue only 21 centers received any assistance under general revenue sharing (10 per cent of respondents; 14.9 per cent of those requesting assistance).

Only one of these 21 centers received funding via the state allocation, 18 were funded through local government sources, and two did not indicate the source of their funds.

Received funding from localities	18
Received funding from State	1
Received total funding, did not identify source	2
Total	21
Did not receive funding	199
Sought funding but did not receive funds	128
Did not respond to this question	2

Over half of the centers receiving assistance had pursued both local and state sources of funds, as follows:

Funded by Local Governments: 9 centers contacted both state & local agencies; 9 centers contacted only local government.

Funded by State: 1 center contacted both state & local agencies.

Did Not indicate source of RS funds: 2 centers contacted both state & local agencies.

Thus 12 centers contacted both their state and local government, while 9 contacted only the local agency. (All 18 of these centers were funded from general revenue sharing funds.)

USES FOR REVENUE SHARING FUNDS

Revenue sharing funds can be used for a variety of purposes by community mental health centers, but CANNOT BE USED TO MATCH ANY FEDERAL GRANT.

Centers receiving revenue sharing funds plan to use them for the following purposes: Operational costs; development of a forensics service; adult services; children, youth, and family services; drug abuse programs; alcoholism programs; MR programs; general program expansion; new outpatient services for indigents; support for outreach worker in community (operational costs only); community-based programs previously funded under title IV–A, Social Security Act; travel expenses; staff expenses; construction and other capital outlays.

DOLLARS AWARDED

Although not specifically asked for in the survey, some centers volunteered the following information on the amount of funds received under general revenue sharing. This data is included as a guide to indicate what other centers might expect to receive, and is not necessarily an accurate statistical picture of all revenue sharing funds awarded to CMHC's. (Unless otherwise indicated, these amounts are for one calendar year): $1,400; $2,000; $15.00 per day for drug and alcohol programs; $20,000 for drug program; $740; $330,000 for construction.

SOME CENTERS STILL HOPEFUL OF RECEIVING FUNDING

A total of 29 respondents indicated that they are still hopeful of receiving assistance through general revenue sharing. Uses to which this money might be put are shown below:

Police consultation and screening tests for promotions for Police Department.

Reasonable expectation of receiving funds to be used for expansion of residential treatment and rehabilitation program.

Revenue sharing mechanism not yet in operation—center has played a major part in planning and expects to receive its "fair share" of funding.

Support for therapeutic community, and staff increases for alcohol program (this center has already received $20,000 contribution but expects additional funding).

Program expansion.

Operating costs.

Capital outlays.

Substitute for Title IV–A money.

Substitute for expiring federal grant (commitment made by county in one instance, grant expires in three years).

Information and referral program.

Outreach program.

Drug Program.

CMHC's Which Have Received Payments From General Revenue Sharing Funds—February 1973

(COMPILED FROM A SURVEY BY THE NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS)

Name of center	*Center's Comment on Revenue Sharing Funds*
Prairie View MHC, Newton, Kans	$5,000 for drug and alcohol program.
District 5 MH Board, Inc., Gainesville, Fla	One county, put $2,000 into a mental health contingency fund.
Hennepin City MH–MR, Minneapolis, Minn	Still in some doubt, but tentatively approved.
Community MHC of Colusia County, Daytona Beach, Fla	
Appalachian MHC, Elkins, W. Va	Requested $40,000 from 10 county governments, expects to receive only $6 to 7,000.
Jackson MHC, Jackson, Tenn	
MH–MR Community Center, Corpus Christi, Tex	
Clayton MHC, Riverdale, Ga	This Revenue Sharing money is useful, but we could not continue to operate without NIMH staffing funds.
MHC of St. Joseph's County Inc., South Bend, Ind	$20,000.
Huntsville-Madison County MHC, Huntsville, Ala	These funds already promised by our local government before Revenue Sharing enacted. However, they have been allocated from Revenue Sharing dollars.
Region MH–MR Center, Oxford, Miss	For construction project.
Mid-Missouri MHC, Columbia, Mo	
East Arkansas Regional MHC Inc., Helena, Ark	Revenue Sharing funds total 3½ per cent of our budget.

Nine other centers reported receiving revenue sharing funds but did not identify themselves. One of these nine received $1,400. Nine centers were in the following states: Tennessee, Colorado, Ohio and Texas.

Mr. Rogers. Our next witness is Mr. Ashar S. Tullis, executive director, Kentucky Association for Mental Health, Inc., Louisville, Ky. The committee welcomes you and will be pleased to receive your statement.

I might say Dr. Carter cannot be here because of illness in his family, and I am sure he would like us to express his appreciation for your presence here today.

STATEMENT OF ASHAR S. TULLIS, EXECUTIVE DIRECTOR, KENTUCKY ASSOCIATION FOR MENTAL HEALTH

Mr. Tullis. My name is Ashar S. Tullis. I reside in Louisville, Ky., and am executive director of the Kentucky Association for Mental Health. This statement has been approved by the executive committee of the Kentucky Association for Mental Health. The Kentucky Association for Mental Health is the citizens' voluntary organization working toward the improved care and treatment of the mentally ill, for improved methods and services, prevention, detection, diagnosis, and treatment of mental illness, and for the promotion of mental health.

I have been the executive director of the Kentucky Association for Mental Health since 1964. During this period of time, the State of Kentucky developed a plan for mental health in Kentucky known as "Pattern for Change." With the passage of the legislation providing funds for community mental health centers, this plan was put into effect. Although I understand this hearing does not pertain directly to H.R. 5608 but rather to an oversight of the legislation, I would like to go on record here, both for myself personally and for the Kentucky Association for Mental Health, as in support of this legislation.

I want no misunderstanding concerning the testimony I might give here in relationship to the way in which the community mental health centers program has been untilized in the State of Kentucky to be interpreted as any opposition to this legislation but, quite the contrary, in wholehearted support of that legislation. Not only are we in support of the legislation as it pertains to mental health but also as it pertains to comprehensive health planning.

Kentucky has been fortunate in securing funding for its community mental health centers program and thus being the first State to have a complete coverage of community mental health centers. This program has meant a great deal to Kentucky, the mentally ill of Kentucky, and to the future of mental health in Kentucky. Many of the centers, I would say the majority of the centers, have operated in an acceptable manner and have attempted to serve the mentally ill people of Kentucky. According to the report of the department of mental health, State of Kentucky, in fiscal year 1972, 42,921 people received help through the community mental health centers and 26,312 were assigned continued formal treatment programs. We do not know whether this constitutes quality care or not. We do not know whether this is good performance on the part of staff or not.

This past year, the Kentucky Association for Mental Health, in cooperation with the Kentucky Psychiatric Association, completed a "Survey of Mental Health Needs in Kentucky." The conclusions and recommendations of this survey were wholeheartedly endorsed by the parent body of the Kentucky Association for Mental Health but failed to receive such an endorsement from the Kentucky Psychiatric Association. The study committee was made up of representatives of the lay population in the Kentucky Association for Mental Health as well as professional representatives from the Kentucky Psychiatric Association.

One of the major recommendations of that survey is that the Governor of Kentucky appoint an 18-member standing commission whose duty it will be to evaluate the delivery system of mental health in Kentucky. This commission should be made up of 9 professionals, 7 laymen taken from a list of 21 recommendations made by the Kentucky Association for Mental Health, at least 3 of whom should be members of comprehensive mental health center boards, and 2 members of the Kentucky General Assembly.

I point out this recommendation because it is in line with the testimony I have to give to this committee. Despite the support of the community health centers program by the Kentucky Association for Mental Health, there has been much found amiss in the program. I know that Dr. Carter and others here are familiar with what hap-

pened in the Barren River Mental Health Center, which covers the Glasgow-Bowling Green area. After investigation, it was found that the program's administrator had drawn cash advances against his future earnings, a staff attitude problem resulted in depriving patients from one section of the region of a hospital facility in another section, the program included no drug addiction and alcoholism services, reports to the Federal Government on expenditures of Federal aid were a year and a half overdue, the agency operated almost a year without any internal auditing procedures, and financial records were so incomplete that a State audit of the program took several weeks more than had been anticipated.

This is certainly not the only example of problems which have arisen which resulted in poor quality treatment for patients. It might be said in many cases that too much money came too soon and was not able to be used properly to give quality mental health care to the mentally ill people of the region it was intended to serve. Very recently in Louisville, Ky., a reporter of the Courier Journal, under direction of a local psychiatrist, presented himself as a potential suicide to the crisis center, which is supposed to offer crisis intervention services on a 24-hour-a-day basis. It took 3½ days for this man to get any attention from the center whatsoever.

Although these programs are giving services to the people who need them in their regions, there is still a great deal to be desired. I have only given a couple of examples of such occurrences across the State of Kentucky. I point these examples out not to criticize the program but to indicate that there is a great need in the program for citizen evaluation. This evaluation should be made over and apart and separate from the NIMH or State programs, which would be placed in the position of judging themselves. One of the board members of the Barren River Mental Health Center, quoted in the October 4, 1972, issue of the Courier Journal, said:

> I am appalled that NIMH has left it up to the Department of Mental Health to investigate how the Mental Health Centers use Federal money. It is asking the State to keep an eye on itself.

I am aware of and understand the misgivings which have been held on the part of many Congressmen in view of the misuse and misadministration and lack of quality care which has resulted in some of these programs. However, none of this diminishes the need of the mentally ill; and certainly, since 1 out of every 10 people of these United States is affected to the point that they need professional care, the priority for the mentally ill should continue.

In line with the development of the community mental health centers program, there has been a deemphasis of the State hospital program. May I again quote to you from the "Survey of Mental Health Needs in Kentucky":

> The Joint Survey Committee acknowledges the national trend of the past decade in reducing the resident population of mental hospitals, we believe that reduction in hospital size and seeking alternatives to hospitalization represents a refreshing development. However, the Committee is of the opinion that the pendulum may have swung too far. Admission to a mental hospital and the adequate length of stay still represents proper and often necessary method of treatment. The present and future policies for admission and treatment in mental hospitals merit careful and continuing review to ensure that a balanced program including adequate hospitalization is presented.

We believe that the deemphasis of the mental hospital and the resulting decrease in hospital population has not been due to the efficiency of the community mental health centers but rather to the decision of those in authority that the hospitals are going to be de-emphasized; and, therefore, we do not believe that necessary attention has been paid to the requirement for proper hospitalization, which is one of the required criteria for the community mental health centers program. In addition to this, the centers have been able to pay larger salaries for persons with equal qualifications. Therefore, there has resulted a further diminishing of the quality care available at our hospitals.

It is possible that, perhaps, we have misjudged some of the programs. It is also possible that our conclusions concerning both the community programs and the hospital programs are not entirely accurate. However, because there has not been accurate information available and there has not been an outside evaluation of this program, we believe that, when this program is renewed, it should include a very positive program, financed by the Federal Government, to provide for this evaluation.

It is our recommendation that a commission be created in each State comparable to the one which is outlined in the "Survey of Mental Health Needs in Kentucky" and that the funding be provided for and made mandatory by the renewal legislation for the Community Mental Health Centers Act. Without this, the administration, the Congress of the United States, and the citizens of these States cannot be assured of the quality of program which will be necessary to justify the expenditure of funds for this program.

Mr. Chairman and members of this committee, I urge you to act to create this evaluation program. The Kentucky Association for Mental Health has nothing to gain from this legislation one way or the other. The only gain that we or any other citizens of the United States may have is the knowledge that the great need of the emotionally and mentally ill be served. I know it is your obligation to see to it that the money which is appropriated for Federal programs is properly spent. I know of no better way that you can assure yourself that the emotionally and mentally ill people will be served and that you and the rest of the country can be aware of the fact that they are being properly served than to create such an evaluation group in each State.

Mr. Chairman, members of the committee, this concludes my testimony on behalf of the emotionally and mentally ill people of these United States. I thank you for the opportunity of making this testimony on their behalf and again with to conclude by urging you to act to renew the Community Mental Health Centers Act with this provision so there will be an evaluation of this program for those who need it so desperately.

Mr. ROGERS. Thank you very much for your testimony. Mr. Preyer.

Mr. PREYER. Thank you for your very frank testimony. I just wondered why the Kentucky Psychiatric Association failed to endorse your survey.

Mr. TULLIS. That, of course, calls for an opinion judgment as to why they turned it down. My own opinion is that they feel the survey did not sufficiently compliment the existing program. That would be my evaluation.

Mr. PREYER. They are in favor of the existing program?

Mr. TULLIS. The Psychiatric Association is made up of about half of members in public service.

Mr. PREYER. Thank you.

Mr. ROGERS. Mr. Nelsen.

Mr. NELSEN. I noted in one part of your testimony you said the State would be supervising itself. Yet your final recommendation suggested a sort of survey.

Mr. TULLIS. This group would be independent of the operation of the program itself.

Mr. NELSEN. I see. Thank you.

Mr. ROGERS. Dr. Roy.

Mr. ROY. I have no questions. I thank you for your statement.

Mr. ROGERS. Mr. Hastings.

Mr. HASTINGS. You mentioned at one point you have given "only a couple of examples of such occurrences." Those irregularities you state—I have not been familiar with them before. Would that indicate there has been a great number of them in Kentucky?

Mr. TULLIS. As I stated, most centers are operating, to our knowledge, in an acceptable manner. I think the concern we have is that there may be more of these than we know about unless there is an outside group looking at them.

Mr. HASTINGS. We should follow that up. Then, too, you feel the State of Kentucky is not able itself to institute the procedures necessary to find out what the irregularities are?

Mr. TULLIS. I think there is an unwillingness to do so for the reason no one likes a citizen group looking over his shoulder.

Mr. HASTINGS. Isn't that inconsistent with what we are doing? We try to develop it with Federal seed money and phaseout so it becomes a community function.

Mr. TULLIS. With groups operating from the State level, I think this could assure that the Federal and State money is well spent.

Mr. HASTINGS. They want the Federal Government to pay for it?

Mr. TULLIS. I think it should be mandatory at this juncture but not always paid for by the Federal Government any more than the total program would be paid for by the Federal program.

Mr. HASTINGS. I am appalled that you have to admit to us the State is not capable of taking care of such irregularities. I would hope this committee would never have to impose its views on every State in the Union.

Mr. TULLIS. I didn't think there was any suggestion in here that the State could not handle these problems or that the Federal Government should take care of these problems. I am suggesting there be an outside evaluation in each State. I think your own expression, the rabbit watching the lettuce patch, is the matter of whether the people who are involved in the program itself are really able to properly evaluate what is being done.

Mr. HASTINGS. We have some down here knowing what the lettuce patch is about, too.

I gather, from your testimony, that you are advocating that we start returning to the utilization of mental hospitals?

Mr. TULLIS. No, I do not. I thought we made that clear in saying we thought this was a refreshing development. What I am suggesting is—and it was the opinion of the committee and is the opinion of the

association—that certain things have occurred which would indicate that the State hospital needs to be maintained and needs to be maintained on perhaps a broader basis than it now looks.

Mr. HASTINGS. The language on page 4:

We believe that the deemphasis of the mental hospital and the resulting decrease in hospital population has not been due to the efficiency of the community mental centers * * *.

Mr. TULLIS. May I give you an example?

Mr. HASTINGS. Yes, but it is inconsistent with the testimony we have received from across the country.

Mr. TULLIS. I realize that and, as I say, we are concerned—as I say in the testimony, we believe this is the direction of how things should go. However, there should not be a deemphasis of the quality of the treatment or that there should be an actual letting of patients out of the hospital for the purpose of depopulating the hospitals.

An example of what I am talking about is, for instance, in the Louisville area central State hospital, at one time in the period of one month, 499 patients who were on convalescent leave—that means they were out in the community—they were cut off from the hospital. They were, by a stroke of the pen, eliminated from the hospital.

We were told, when we objected to this, that these names had been turned over to the community health center and it was their obligation now to look after these people. I appeared at that board that night to ask them what they were going to do about those 499 patients. They said they knew nothing of those 499 patients, they had not agreed to take them, had not been asked to take them, and they had no names for these 499 people.

It was only upon the urging of the association that we were able to get the centers to the point that they found out who these people were and tried to locate them. We have been working on this with them for about a year now in order to try to locate these 499 people.

Mr. HASTINGS. Does this indicate a rivalry between the community mental health centers and the mental hospitals?

Mr. TULLIS. I wouldn't say there was any rivalry.

Mr. HASTINGS. There doesn't appear to be much cooperation?

Mr. TULLIS. I would say there is a great deal of cooperation since——

Mr. HASTINGS. 499 patients released from the hospital to the community health centers and they didn't know about it——

Mr. TULLIS. Yes. I would say something is lacking. For that reason, we are saying there should be an evaluation of what is happening.

Mr. HASTINGS. Don't misunderstand; I am not passing any judgment on the State of Kentucky, but we have an overriding concern about the total community mental health program. I would frankly think throughout the country the experience, particularly of the suicide, taking 3½ days to get help——

Mr. TULLIS. This is not the whole program. What we are saying is: There is enough of these things so that we believe there should be outside evaluation from citizens' groups with proper professional advice. We are not opposing the direction of the community mental health centers.

Mr. HASTINGS. I think you made that very clear.

Thank you, Mr. Chairman.

Mr. ROGERS. Let me just ask you: Have you requested an outside evaluation from the Department of HEW?

Mr. TULLIS. Not from HEW.

Mr. ROGERS. It is permitted in the law that evaluation of programs may be conducted by contract, by grant, or any other payment on provision of the act up to 1 percent of the authority HEW has. I think, if the situation is as bad as you say, you could request that the Department have an outside group come in under contract. Perhaps you could get funding from HEW.

I am concerned that a State hospital would cut off people without making contact with the community mental health centers to see that they would be picked up. I don't think that is a criticism of the community mental health centers, but it is a criticism of the State hospitals that they would release people like that.

Mr. TULLIS. It is a criticism of the system itself.

Mr. ROGERS. How would the centers know unless they told them?

Mr. TULLIS. The State hospital felt they had told them.

Mr. ROGERS. Did they have it in writing?

Mr. TULLIS. Not that anybody could find. We couldn't find the names for a while.

Mr. ROGERS. That is absurd.

Your testimony has been most helpful, and we are grateful to you for being here.

Our last witness is Dr. Dale H. Farabee, Commissioner of the Department of Mental Health, Frankfort, Ky. Dr. Farabee, we welcome you to the committee and will be pleased to receive your testimony. If it is agreeable with you, we will put your full statement in the record and, if you would highlight the points you think the committee needs to know, that would be helpful.

STATEMENT OF DR. DALE H. FARABEE, COMMISSIONER, KENTUCKY DEPARTMENT OF MENTAL HEALTH

Dr. FARABEE. I am Dr. Dale H. Farabee, Commissioner of the Department of Mental Health about which you have just heard, and I am prepared to discuss that.

The basic statement that I have here will be entered into the record with exhibits and two addendums for your perusal, if you will.

Mr. ROGERS. Yes; I think we will have the statement and addendums for the record and the report "Patterns of Progress 1971–72," by the Kentucky Department of Health for our committee file.

Dr. FARABEE. Would you look at these pictures, Mr. Chairman? These are simply to provide you with some visual information about the community mental health center programs.

Mr. ROGERS. Certainly.

Dr. FARABEE. I would like to enter into the record for the committee's consideration the record of the State and National Institute of Mental Health original examination of the Bowling Green and Barren River operation. I will provide a copy for you for your files.

Mr. ROGERS. I see we have a vote. We have 5 minutes before we have to go.

Dr. FARABEE. I would say very quickly that the primary points brought up in my statement that affect the relationship of the Ken-

tucky program to the national program is that—in my opinion and on judgment from other persons around this country including NIMH—the Kentucky program is one of the better programs in this country with respect to the comprehensiveness and administrative integrity in the program and so forth.

I make no excuses for the difficulty and problems that have occurred in starting from scratch and developing a massive program in a very short period of time.

One of the primary problems encountered anywhere in the country, and particularly in Kentucky, is the development of sufficient adequate administrative personnel. Much information has previously been relayed on this matter to Congress toward the development of training programs with the universities for administrative personnel in this field—they are a breed in themselves—to run the complicated community mental health care centers.

Our program is comprehensive in that it is operated in all 15 regions set by the Kentucky government through the Kentucky program planning office, and it operates in 15 regions in terms of planning and development.

Consequently, in the community mental health program, we operate along with the health department, department of economic security, and others, in developing unified programs. We have an arrangement of exchange of moneys, interaccountability between both rehabilitation, department of economic security, under 4–A and 16, and such other programs as title I of ESA. The centers are duplicating on a regional level the cooperative interdepartmental programs of the State departments. The centers are operated in fact by regional boards of private citizens who constitute their own local review and evaluation boards, who are not coerced on the board by any means, and who are acting in a partnership with the State, with the Federal Government and with local governments to carry out a program involving the community and looking for the development of all possible programs.

The main emphasis is on catalytic action for the development of additional programs where they do not exist; but, as the previous gentleman testified with respect to the development of affiliation agreements, the primary emphasis has been on the development of affiliation agreements to get private programs that were already in existence to affiliate and involve themselves as part of the overall program.

Consequently, the money situation has been one which Kentucky has fortunately worked through over the past 7 years. Two of our centers are in their seventh year and seven more are in their next-to-last year. We feel that the present circumstances are such—with the multiple sources of financing established over the years—that the centers will be able to operate to a great degree without additional Federal funding, if that is the final decision.

However, we feel it would have been impossible for the centers to have been established without the initial staffing grants. Like any man running a grocery store, it costs as much money to operate a store for one customer as for a hundred. If you don't have the basic starting costs and your operating and administrative costs, you can't produce the volume that will cut your costs.

Mr. ROGERS. You are saying: For the establishment of a community mental health program, they do need start-up money?

Dr. FARABEE. Yes, because the amortization of initial start-up costs is necessary, and to recruit professionals.

I would like to show you this "Pattern for Change." This was a pattern adopted by the Kentucky commission which was funded by the 1963 Congress, and this has been the operational guidelines under which the Department of Mental Health has set the program. We are following it to a "T."

[Testimony resumes on p. 108.]

[Dr. Farabee's prepared statement and attachments follow:]

STATEMENT DR. DALE H. FARABEE, COMMISSIONER, KENTUCKY DEPARTMENT OF MENTAL HEALTH

The Kentucky Department of Mental Health has endeavored over the past few years to implement a systematized comprehensive program to alleviate multiple mental health problems in the Commonwealth, specifically in the areas of diagnosis, treatment and rehabilitation of mental illness, mental retardation, alcohol and drug abuse and addiction and to abet preventive services through education.

The word "system" pinpoints the essential ingredient in this program, for it is a coordinated, integrated method of delivery of services rather than a package of disjointed, unrelated programs and facilities. The system connects and utilizes an extensive array of state, private and quasi-public agencies, including 64 state and local hospitals; 139 day care training units for the retarded; 26 adult activity centers; 16 sheltered workshops (in cooperation with the Bureau of Vocational Rehabilitation, Department of Education), and numerous other private physicians and caregivers. The program is generating much of its own financial and professional staff support and is flexible enough to respond to changes in the years to come. Through such a system of affiliated organizations, Kentucky has become the first state in the nation to achieve a realistic continum of care between inhospital services and community programs throughout its geographic area.

The recommendations of the Kentucky Mental Health Planning Commission, whose report, *Pattern for Change*, was accepted by the Commonwealth in 1966, have provided direction and authority for the Department in the development of the program through the past three state administrations. Re-evaluation and study of mental health services by that Commission only seven years ago, charted the new directions of progress for the Commonwealth.

The Department of Mental Health utilizes as its primary philosophy the following excerpt from *Pattern for Change:*

I quote:

"To realize the full potential of our mental health and mental retardation services, which a proper organization can bring, we must establish a new pattern of developing services, a pattern of strong community involvement and support. It has become clear that the treatment of the mentally disturbed can be shorter and more effective if carried on close to the home base of the patient. The local community is the natural setting and population base for coordinated programming—for the prevention of mental illness and mental retardation, for the promotion of mental health, and, to an increasing extent in the future, for the treatment of most persons with mental health problems. Therefore, to meet the challenge confronting us in providing for the mental health needs of Kentucky, the direction we must move in is abundantly clear. It is towards meeting these needs in the community. It is a continuation of the direction in which we have already begun to move, leaving behind traditional concepts of custodial isolation and embracing new potentialities of prevention, treatment and rehabilitation through community-based services."

Gentlemen, these words were written in 1966. Are they any less true today? It was in response to this clear charge that the Department of Mental Health set forth to develop the "circle of services" which is the fundamental strength of the program as it is now existent.

In keeping with the Kentucky Program Development Office decision to initiate 15 regional planning areas encompassing the 120 Kentucky counties, the Department of Mental Health implemented *Pattern for Change* by developing in each region (as permitted under Kentucky statutes) a regional mental health-mental retardation board composed of citizens willing to function as the operators of

local mental health-mental retardation programs. Additional statutory authority extended that responsibility to alcoholism and drug programs in succeeding legislative sessions. Today, these regional boards constitute a vehicle for cooperative federal, state and local relationships geared toward effective service delivery system. Each authorized regional board was encouraged to initiate a request for a federal grant-in-aid through Public Law 88–164 and the subsequent Public Law 89–105, with "seed" money from the Kentucky Department of Mental Health as matching funds.

To utilize the federal construction funds, 2.5 million of state revenue bond dollars were made available to the regional programs to supplement local funds. The result was 188 new inpatient psychiatric beds funded and 26 new mental retardation facilities. With exception of 30 inpatient children's beds, the remaining facilities have been allocated to communities and private hospitals as a means of providing additional support to the community center programs throughout the state. Each of the 15 regions received some share of the bond and federal funding in one phase or another of the construction program. Staffing grants were received in all of the 22 catchment areas operated by the 15 regional boards. Alcohol and drug grants from state and federal sources, as well as Title I ESEA and Title IV–A and Title XVI and XIX dollars, were available as services were expanded through affiliates.

Fundamental to the success of this comprehensive approach are the following concepts: (1) The program must provide access to multiple services to people in every county of the state. (2) Services must be provided to include prevention, treatment and rehabilitation in the areas of mental illness, mental retardation, alcoholism and drug addiction. (3) Medical and social services must be integrated to assure continuity of care. (4) A complete mix of available financial and clinical resources must be utilized through contract and affiliation agreements rather than total dependence upon direct federal or state grant support. A business-like approach is paramount to the multiple financing route, even though it often complicates the lives of the clinical service deliverers.

Even in this short statement four common misunderstandings of the community center system can be cleared up:

They are: that mental health center programs are "simple mental health center-neighborhood psychiatry offices; that state hospitals inevitably are the recipients of the community center dregs that service by physicians alone can cover the need at much less cost; and that mental health center administrative costs are enormous."

First.—The community center concept has always involved multiple service, multi-location programs united through cooperative agreements with existing organizations as well as catalytic action to develop new services to fill gaps. Such affiliations with mental retardation, education, counseling and rehabilitation organizations are fundamental to provision of broad support and dimension to the psychiatric clinic, and relieves the overwhelming demand for direct psychiatric treatment through positive interdiction of cumulative illness. Social services are *not* synonymous with social militancy but are in fact a long recognized and legitimate running mate of community health services.

Second.—Where positive *integration* of community and state hospital services are achieved, nearly always through aggressive state participation in community center development, the state hospital becomes a therapeutic community. Insistence upon community center assistance with discharges and placement of geriatric patients is essential. Shared finances and adoption by the state of such other federal assistance as Title XIX and XVI is of course basic. In Kentucky, we are now concentrating upon raising payment and standards for private nursing, personal and intermediate care homes as an alternate system to huge packages of state dollars to rebuild ancient state custodial facilities. The results of the integrated program are seen in Exhibit I.

Third.—Service costs for private physician coverage alone are no lower than the same *services* provided by the *same* staff in a center, and in fact, if the same *variety* and *amount* of service were to be provided by the *private* sector alone, in all probability the cost would be the same. Furthermore, in the multiple service center, non-profit, and non-competitive, physician, psychologist and administrator alike can share resources. Kentucky's experience with administrative costs is indicated in Exhibit II. As any store manager will attest, it costs as much to open the doors for one customer a day as it does for a volume, and that costs go down proportionate to utilization.

Fourth.—The Kentucky centers started from *scratch*, had to build up utilization, amortize start-up costs, sell service and learn to administer a new program. Two nationally known accounting firms have worked five years with the department in evolving a cost accounting system uniform from state department to center to center. Electronic data processing oriented, this system will be in operation completely by mid-summer. It not only will prevent some of the misinformation commonly hurled at such operations, but will speed up accounting and other administrative processes with concomitant increases in efficiency. Its present status is such as to permit us to provide the information with respect to administrative personnel costs in the Kentucky centers.

Finally, one should point out that while community mental health centers in Kentucky have resolved much of the problem of reducing Federal shares, (see Exhibit III) there is still the very real need to continue to supply other states with the initial assistance from the bill, while they obtain the necessary legislation and personnel, and to maintain a reasonable level of continuing support while the necessary personnel, training and service quality improvement takes place.

It is my opinion that few kudos have been granted for the accomplishments throughout this nation of this program, and it is astonishing even to me as a student of human behavior, how readily the critic hurls accusations, no matter how poorly informed he may be, and even more amazing, how readily his charges are accepted, even in the face of facts and evidence of sincere and dedicated progress and effort. I am confident that the members of our Congress will discern the facts and uphold the benefit available to our nation from this program.

ADDENDUM TO TESTIMONY—I

The Commissioner of Mental Health is authorized to make state grants to the regional programs. In return under KRS 210 he has the power to promulgate rules and regulations governing the eligibility of community mental health programs to receive those grants. The Department of Mental Health has filed with the Legislative Research Commission a number of administrative regulations concerning board representation, methods of selecting members, the system of committees, personnel accountability, and various other components of the program. Each year the boards submit to the Kentucky Department of Mental Health a complete Plan and Budget for the next fiscal year, outlining in explicit detail all components of services offered by the comprehensive care centers. No program is eligible for a grant until its Plan and Budget has been approved by the Commissioner of Mental Health.

In addition, the law mandates that the Commissioner shall prescribe standards for qualifications of personnel and quality of professional service. The Department has re-evaluated its monitoring and regulating system. Attached, as an exhibit, are present administrative regulations with the proposed revisions.

The proposed revisions governing Board membership establish not only larger nominating committees and public advertising, but provide that any person who is a legal resident of the geographic region may present a petition with 25 names or more to the board and through this petition becomes a candidate on whom the entire board must vote at its annual election, or when the board replaces vacancies.

New regulations governing personnel regulations are especially significant. At the present time, qualifications, salaries, job titles and names of each person on the center staffs must be submitted with the annual Plan and Budget. The new regulation would, in addition, require that any time after the annual Plan and Budget is approved any change in personnel qualifications, salaries or specifications would be regarded as a revision to the Plan and Budget and must be submitted to the Commissioner for approval prior to implementation.

Another method of control which the Department has recently developed is the computer system. The Department's computer system has gained nation-wide attention and publicity as the first of its kind in the mental health field, providing a wide range of fiscal and personnel information. The Department is at the present time installing video terminals in each of the mental health center's headquarters and in the Central Office of the Department of Mental Health.

These data processing units will serve as devices to transmit personnel and financial information to a central computer operated by the Department of Mental Health and will also have the capacity to serve as a visual inquiry

terminal. These units will provide to the appropriate official of any center in the state, as well as authorized staff members of the Department of Mental Health, immediate access to the financial status of payroll disbursements and of all other types of expenditures in every center in the state. This capacity to retrieve management information will provide a means of monitoring the efficient and effective use of resources and serve as the base for projecting future resource needs in each component of the center program.

Ernst & Ernst, a nationally known accounting firm, has been engaged by the Department to conduct audits annually of all comprehensive mental health centers and to provide, as well, an ongoing management systems study. Included in the exhibits today is the cost allocation plan for the Department of Mental Health recently developed by Ernst & Ernst.

From the inception of the mental health centers the Department of Mental Health directed in its regulations that an administrator as well as an executive director must be employed by the centers. This was to provide administrative and financial accountability. Because of this Kentucky has truly developed multiple sources of funding for each center and is not dependent on any one resource.

However, there has perhaps been misunderstanding about the administrative expenditures of the centers. The exhibit attached to this testimony will attest to the actual administrative overhead in each of the 15 regions. The total expenditures for administrative and clerical personnel range from 8 to 14 per cent with expenditures for clinical personnel ranging from 86 to 91 per cent. Several of the Boards serve multiple catchment areas, such as in the populous Jefferson and surrounding counties.

Addendum to Testimony—II

The average daily census of the four state psychiatric hospitals dropped 55 per cent from 1966, when the first two community mental health centers opened, to March 1973 after the network was completed. Today there is a total of 1988 patients in residence. The hospital staffs have *not* decreased, allowing therefore a more realistic patient-staff ratio. The median length of stay for fiscal year 1972 admissions range from 20.5 days to 25.9 days, with the average stays ranging from 34 to 42 days. A table depicting average length of stay by diagnosis covering admissions in the 1972 fiscal year is enclosed.

Admissions, however, have increased as casefinding and screening services of the centers have accelerated. Ready access to the hospital provides short hospitalization opportunities and rapid return to the community and followup services there.

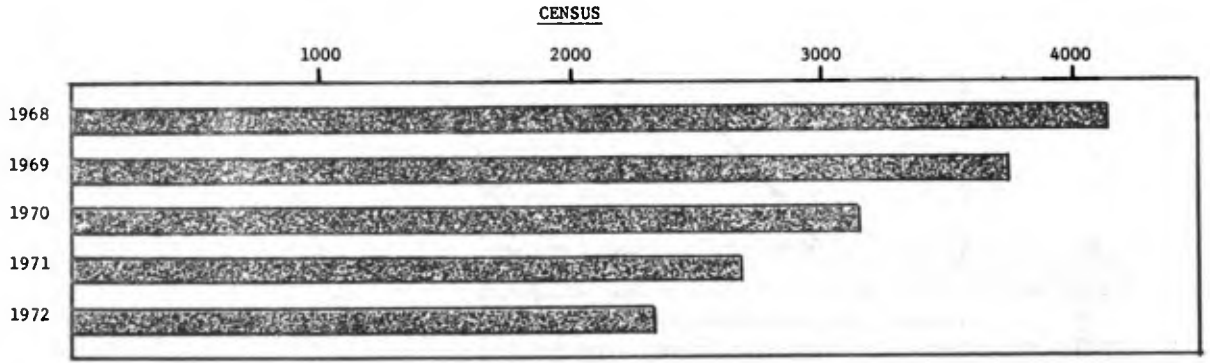
The result of the centers' program has been salutory. Since the advent of the centers, Kentucky has been able to achieve accreditation of all of its state psychiatric hospitals.

The chronic patient load in the hospital has decreased as the centers and the Department have found methods by which to employ the private sector and federal programs to provide care for the chronic brain syndrome and long-term schizophrenic who have comprised as much as 90 per cent of the state hospital population in previous years. Thus, as admissions and readmissions have increased, length of stay in the hospital has dramatically decreased and the complexion of the total hospital population has changed.

The mental health center program has promoted a much rapid acute patient turnover, has forced an increase in the quality of the state hospital staff, and in effect, has helped to bring the state hospital into the mainstream of psychiatric practice. The centers provide a mechanism for pre-screening and post hospitalization follow-up for the chronic patient.

AVERAGE DAILY CENSUS, STATE PSYCHIATRIC FACILITIES

1968 - 1972



1968 VS 1972

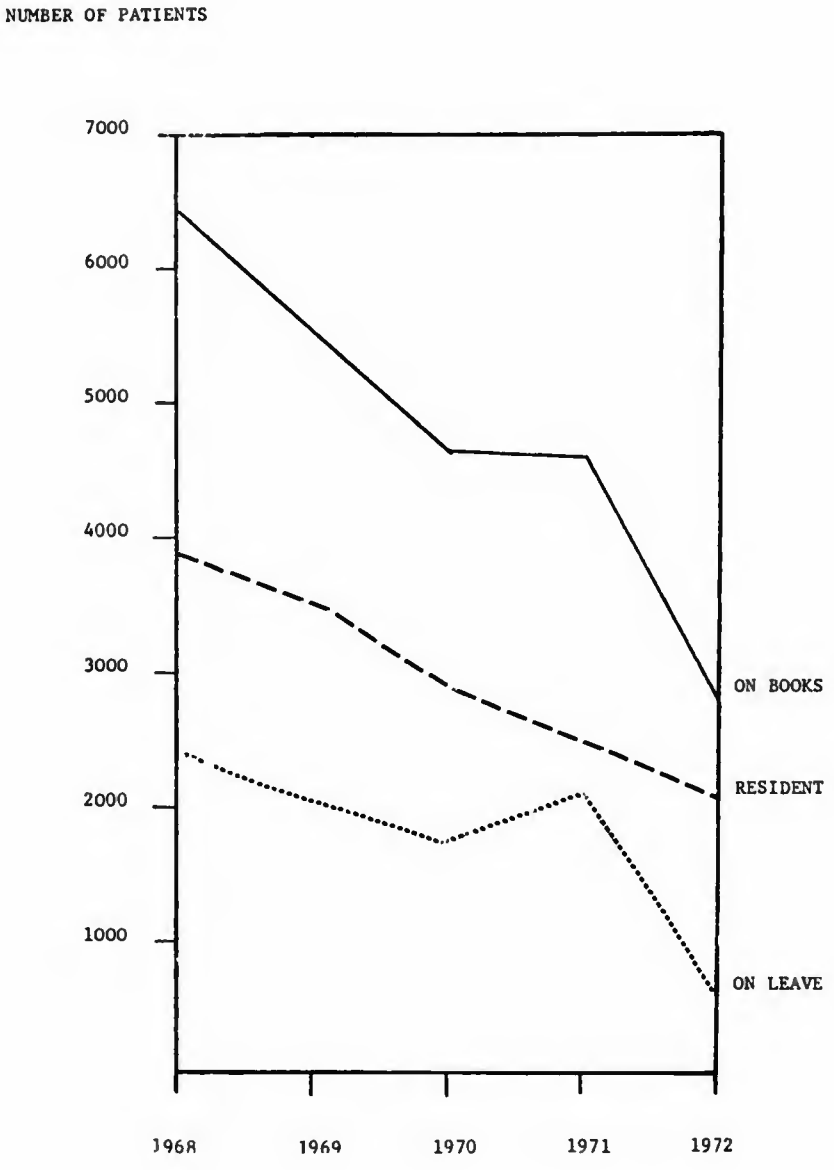
41% decrease

1,820 net decrease

EXHIBIT I

POPULATION TRENDS IN STATE PSYCHIATRIC FACILITIES

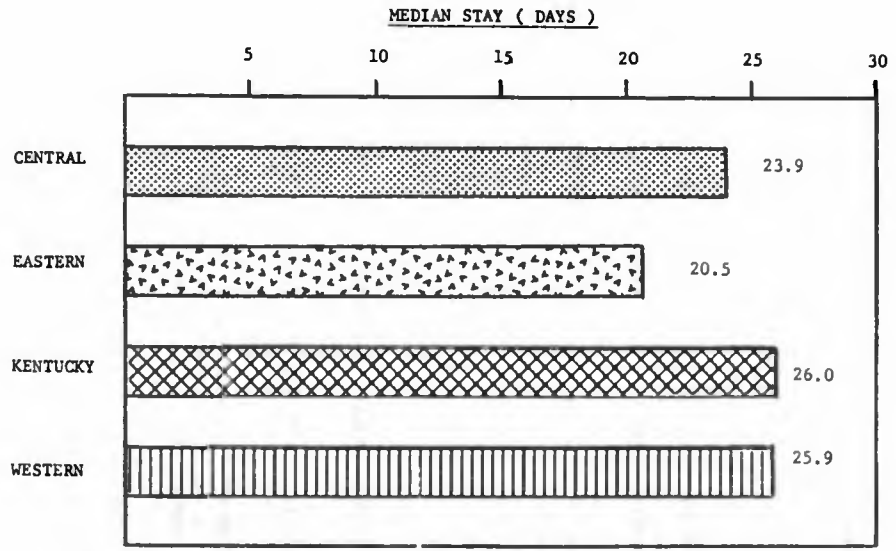
1968 - 1972



MEDIAN LENGTH OF STAY (DAYS)* OF ADMISSIONS** TO STATE PSYCHIATRIC FACILITIES

BY FACILITY

FISCAL '72



* LENGTH OF STAY AS OF 6-30-72.
** TOTAL ADMISSIONS (INCLUDES TOTAL FIRST ADMISSIONS, READMISSIONS, AND TRANSFERS).

INPATIENT OAYS, AVERAGE OAILY CENSUS, STATE PSYCHIATRIC FACILITIES, 1966-73 (THROUGH MAR. 31)

Year	Average census	Inpatient days
1966	4,774	1,742,510
1967	4,562	1,665,130
1968	4,132	1,512,312
1969	3,732	1,362,180
1970	3,134	1,143,910
1971	2,665	972,725
1972	2,312	846,192
1973 (Mar. 31)	2,150	589,024

Note: Percent decrease of average daily census, 1966-73, 55.

ADMISSIONS TD KENTUCKY STATE PSYCHIATRIC FACILITIES, JULY 1, THROUGH JUNE 30, SELECTEO YEARS

Selected years	Central	Eastern	Kentucky	Western	Total
1973 (through March 31)	1,680	1,924	1,564	1,928	7,096
1970	1,287	1,490	1,154	1,467	5,398
1968	1,849	1,437	1,574	1,581	6,441
1965	1,174	1,149	1,514	1,579	5,416
1960	754	1,177	917	1,276	4,124

Note: Excludes transfers between facilities.

OISCHARGES DIRECT FROM THE HOSPITAL, AVERAGE LENGTH OF STAY (OAYS), SELECTED FISCAL YEARS

Fiscal years	Total discharges	Total days	Average stays (days)
1973 (through March 31)	3,679	492,192	134
1972	3,699	375,731	102
1970	3,578	426,804	119

INPATIENT DAYS, KENTUCKY STATE PSYCHIATRIC FACILITIES JULY 1, THROUGH JUNE 30, SELECTEO YEARS

	Central	Eastern	Kentucky	Western
1973 through March 31	137,539	134,720	156,410	143,520
1970	209,905	283,605	298,935	264,625
1968	430,416	345,504	372,222	364,170
1965	517,570	416,465	446,395	482,165
1960	648,970	588,745	596,410	626,705

TURNOVER[1] OF PATIENTS TREATEO, KENTUCKY STATE PSYCHIATRIC FACILITIES (SELECTED PERIOOS)

	Patients treated	Average daily census	Net turnover	Percent turnover
Fiscal year 1972	7,958	2,312	5,646	71.0
January 1973	2,889	2,109	780	27.0
February 1973	2,808	2,083	725	25.8
March 1973	2,845	2,043	802	28.2

[1] Turnover is the difference between unduplicated count of patients treated during the period and the average daily census for the period.

Source: KDMH computer tabulations and monthly hospital reports; prepared by Statistical Section, HW.

LENGTH OF STAY[1] OF ADMISSION[2] TO STATE MENTAL HOSPITALS, FISCAL 1972

Length of stay	Central			Eastern		
	Number of admissions	Average stay	Percent of total	Number of admissions	Average stay	Percent of total
Less than 21 days	708	8.7	43.8	780	8.6	49.1
21 to 29 days	230	24.7	14.3	251	24.7	15.8
30 to 60 days	415	42.6	25.7	317	41.4	20.0
61 to 180 days	220	97.4	13.6	200	94.8	12.6
181 to 365 days	42	257.9	2.6	39	247.4	2.5
Total	1,615	38.2	100.0	1,587	34.4	100.0
Median stay (days)		23.9			[3] 20.5	
	Kentucky			Western		
	Number of admissions	Average stay	Percent of total	Number of admissions	Average stay	Percent of total
Less than 21 days	519	11.4	37.6	531	10.0	32.9
21 to 29 days	259	25.0	18.8	421	24.9	26.1
30 to 60 days	374	41.4	27.1	390	41.6	24.2
61 to 180 days	175	96.8	12.7	204	95.7	12.6
181 to 365 days	53	261.8	3.8	67	245.4	4.2
Total	1,380	42.5	100.0	1,613	42.1	100.0
Median stay (days)		26.0			[3] 25.9	

[1] Length of stay (days) as of June 30, 1972.
[2] Total admissions, includes transfers.
[3] Median.

Source: DPA, KDMH. Prepared by Statistical Section, KDMH.

AVERAGE LENGTH OF STAY[1] FOR ADMISSIONS, BY DIAGNOSIS, KENTUCKY DEPARTMENT OF MENTAL HEALTH PSYCHIATRIC FACILITIES, JULY 1, 1971–JUNE 30, 1972

Diagnostic category	Total	Total days	Average stay (days)
Senile and presenile dementia	37	2,555	69
Alcoholic psychosis	117	4,487	38
Psychosis associated with intracranial infection	238	503	2
Psychosis associated with other cerebral condition	427	28,846	68
Psychosis associated with other physical condition	33	1,718	52
Schizophrenia	1,755	95,302	54
Major affective disorders	212	10,809	51
Paranoid states	34	1,521	45
Other psychosis	109	4,006	37
Unspecified psychosis	2	84	42
Neuroses	490	12,577	26
Personality disorders	194	4,586	24
Sexual deviations	9	173	19
Alcoholism	1,785	38,814	22
Drug dependence	104	2,299	22
Psychophysiologic disorders	1	5	5
Special symptoms	1	20	20
Transient situational disturbances	57	1,425	25
Behavior disorders of childhood and adolescents	4	112	28
Nonpsychotic organic brain syndrome	242	11,782	49
Borderline mental retardation	27	877	32
Mild mental retardation	101	5,056	50
Moderate mental retardation	125	6,875	55
Severe mental retardation	31	2,323	75
Profound mental retardation	7	132	19
Unspecified mental retardation	20	1,918	96
Social maladjustments	23	358	16
Nonspecific conditions	2	5	2
Without mental disorder	12	171	14
Nondiagnostic terms	41	235	6
Undiagnosed	186	3,687	20
Total	6,426	243,261	38

[1] As of June 30, 1972.

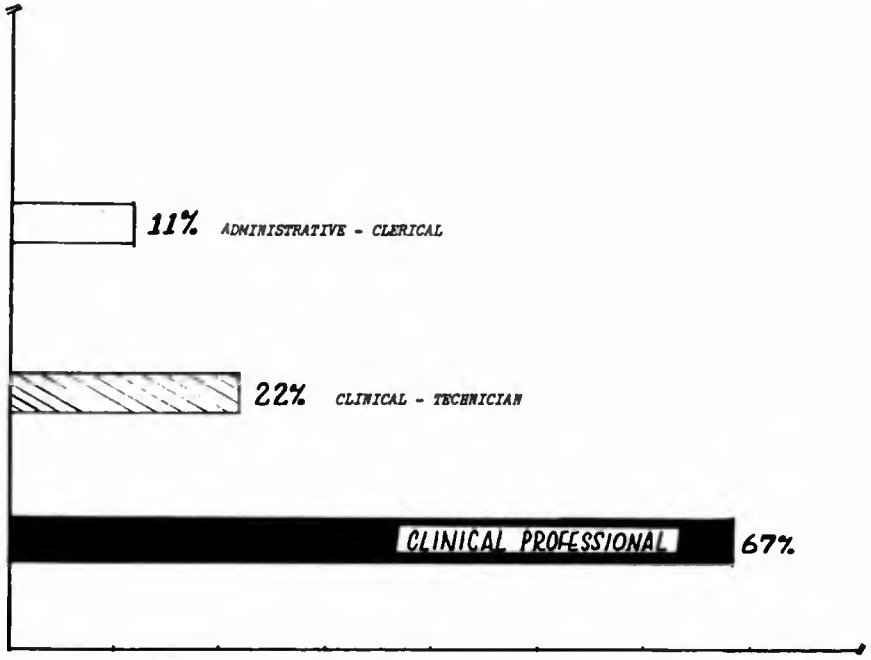
Source: Kentucky Department of Mental Health computer tabulations.

Exhibit II

PERSONNEL COSTS IN

KENTUCKY MENTAL HEALTH CENTERS

BY MAJOR CATEGORIES



TOTAL EXPENDITURES FOR MENTAL HEALTH PERSONNEL BY REGION

Region	Total personnel costs	Administrative and clerical		Clinical, technical		Clinical, professional		Total clinical	
		Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
1	$450,324	$58,452	13.0	$51,456	11.0	$340,416	76.0	$391,872	87.0
2	584,304	82,320	14.0	133,512	23.0	368,472	63.0	501,984	86.0
3	594,142	45,240	8.0	150,780	25.0	398,122	67.0	548,902	92.0
4	950,012	115,296	12.0	259,872	27.0	574,844	61.0	834,716	88.0
5	967,488	99,984	10.0	189,000	19.0	678,504	71.0	867,504	90.0
6	4,010,514	446,011	11.1	629,128	15.7	2,935,375	73.2	3,564,503	88.9
7	1,105,464	111,132	10.0	172,332	16.0	822,000	74.0	944,332	90.0
8	363,600	34,140	9.0	113,232	31.0	216,228	60.0	329,460	91.0
9	307,464	36,240	12.0	90,120	29.0	181,104	59.0	271,224	88.0
10	403,668	46,272	11.0	92,328	23.0	265,068	66.0	357,396	89.0
11	1,302,241	175,171	13.4	179,319	13.8	947,751	72.8	1,127,070	86.6
12	855,564	93,456	11.0	483,276	56.0	278,832	33.0	762,108	89.0
13	2,163,024	212,976	10.0	479,112	22.0	1,470,936	68.0	1,950,048	90.0
14	309,348	43,692	14.0	54,912	18.0	210,744	68.0	265,656	86.0
15	2,488,980	316,464	12.0	537,300	22.0	1,635,216	66.0	2,172,516	88.0
Total	16,856,137	1,916,846	11.0	3,615,679	23.0	11,323,612	66.0	14,939,291	89.0

TOTAL NUMBER OF MENTAL HEALTH PERSONNEL BY REGION

Region	Total personnel	Administrative and clerical		Clinical and technical		Clinica and professional	
		Number	Percent	Number	Percent	Number	Percent
1	48½	10	21.0	10	21.0	28½	58.0
2	79	14	17.7	30	37.0	35	45.0
3	75	7	10.0	34	45.0	34	45.0
4	134	20	15.0	60	45.0	54	40.0
5	125	20	16.0	42	33.0	63	51.0
6	446	57½	12.9	117	26.2	271½	60.9
7	135½	23½	17.0	40	30.0	72	53.0
8	54	6	11.0	28	52.0	20	37.0
9	40½	5½	14.0	19½	48.0	15½	38.0
10	56	6	10.5	23	40.0	27	49.0
11	167½	31¼	18.7	41½	24.7	94¼	56.6
12	134	16	12.0	68½	51.0	49½	37.0
13	285	38	13.0	102	36.0	145	51.0
14	33	7	21.0	11	33.0	15	45.0
15	310½	46½	15.0	111	36.0	153	49.0
Total	2,123½	308¼	14.5	737½	34.7	1,077¼	50.8

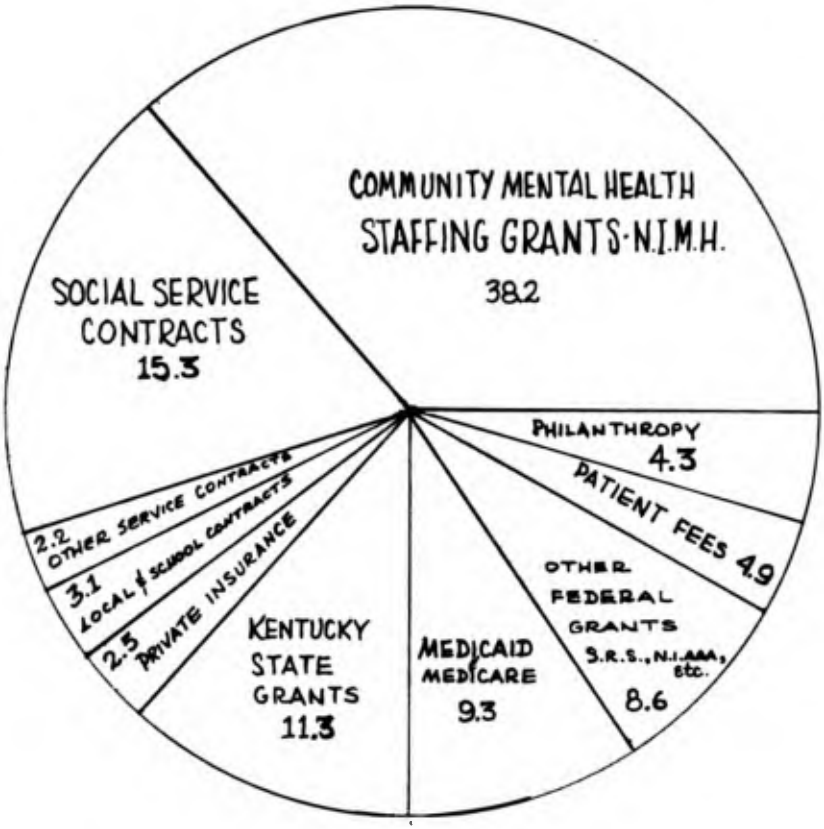
TOTAL COST OF MENTAL HEALTH PROGRAMS, BY REGION

Region	Total cost (operating and personnel)	Administrative and clerical		Clinical technicians		Clinical professionals	
		Number	Percent	Number	Percent	Number	Percent
1	511,731	66,435	13	58,211	11	387,085	78
2	671,613	94,542	14	153,597	23	423,474	63
3	698,990	53,628	8	176,992	25	468,370	67
4	1,117,661	135,413	12	307,137	27	677,110	67
5	1,162,485	119,483	10	226,049	19	816,951	71
6	4,557,402	506,188	11	716,630	60	3,334,584	73
7	1,285,423	129,127	10	201,125	16	955,170	74
8	422,800	39,468	9	131,584	31	251,748	60
9	341,626	40,339	12	100,029	29	201,259	59
10	463,986	52,906	11	106,201	23	304,878	66
11	1,514,202	202,729	13	208,997	14	1,102,502	73
12	1,043,370	114,114	11	588,447	56	340,807	33
13	2,637,834	260,457	10	583,570	22	1,793,806	68
14	368,271	51,941	14	65,518	18	250,811	68
15	2,998,771	377,638	12	649,454	22	1,971,678	66
Total	19,796,182	2,244,408	11	4,271,541		13,280,233	
Grand total				17,551,774			
Percent				22		67	
Total percent				89			

EXHIBIT III

KENTUCKY COMMUNITY MENTAL HEALTH CENTERS

REVENUE



Mr. ROGERS. Thank you very much. We appreciate your testimony and your being here today.

Are there any questions?

Thank you very much.

Dr. FARABEE. May I add one thing. There was a rational explanation for "the 499 persons"—mentioned in the testimony preceding mine—and that was not the correct number. "Convalescent leave" means they are in nursing homes—they are there or at home. It was fully knowledgeable by the home where they were, and it was merely an administrative change in the recordkeeping mechanism, by which they were discharged, with the centers later picking up the care. There was no problem in our minds ever about the situation.

Mr. ROGERS. Thank you so much. We appreciate your giving us this testimony.

[The following letter and attachments were received for the record:]

DEPARTMENT OF MENTAL HEALTH,
Frankfurt, Ky., May 18, 1973.

HON. PAUL ROGERS,
Chairman, Subcommittee on Public Health and Environment,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN ROGERS: I was deeply appreciative of the opportunity to testify at the oversight hearing on the Community Mental Center Act (HR 5608) on May 9.

The great knowledgeability and humane concern of the subcommittee members were most heartening to all of us who have been in the field developing community mental health programs. I left Washington much encouraged about the outcome of HR 5608 and the future of federal support for community mental health.

As you will remember, the pressure of time left no opportunity for the committee members to direct questions to me. Therefore, I wonder if it would be possible for an additional statement to be placed into ther printed record of the hearings answering some of the questions undoubtedly raised by the testimony preceding mine. In that way there would be a full record available in the event of any future debates concerning the Kentucky mental health program. I have taken the liberty of enclosing this and would be most grateful if it were possible to enter this statement as an addendum to the testimony.

At any time in the future that you may wish clarification or additional information from me, please be assured I would be delighted to reply either personally or by mail.

Respectfully,

DALE H. FARABEE, M.D.,
Commissioner.

ADDENDUM TO TESTIMONY OF DALE H. FARABEE, M.D.—MAY 9, 1973

Since the inception of the Kentucky comprehensive community mental health program the Department of Mental Health, mindful of its regulatory responsibilities, has built a quality control component into our system. From the beginning it has been a stated and often reiterated objective of Kentucky's program that the centers provide the highest possible quality of care. In no way was this, however, to be confused with a traditionalistic approach that might prevent the development of creative programs and innovative methods of delivering services, particularly necessary because of Kentucky's geography.

From time to time it has become apparent that those who question the quality do not have first-hand knowledge of the actual performance of the centers in relation to the patients, but are questioning new and innovative ways of presenting these programs.

At any time that innovative programs are developed, those who are more comfortable with traditional approaches, no matter how limited, appear to be threatened and uncertain of the more creative, more wide-ranging approaches.

To further enhance its evaluative capability the Department of Mental Health has within the past year established in the Office of the Commissioner a Licensure, Standards Research and Development Section. In addition to the staff necessary to regulate statewide alcohol and drug abuse programs in accordance with legislation enacted by the 1972 General Assembly, this section includes an evaluation component to provide measurements and scientific study methods for review and study of all facets of the mental health center programs, and of the department's own facilities. This section is at present directed by a staff member who holds two Ph.D. degrees—one in mathematics and one in clinical psychology.

In tandem with the nationally recognized computer system of the department described earlier in our testimony, and the regularly scheduled clinical on-site evaluations by department staffs and outside consultants, this evaluation section places the Department of Mental Health in a superior position to judge quality of treatment and performance of the centers.

In addition, centers around the state have developed client satisfaction questionnaires and their own evaluation components which will also provide considerable information on the efficacy of the program in the future.

Since the "Survey of Mental Health Needs in Kentucky" has been placed into the record by the testimony of Mr. Ashar Tullis, I feel it is necessary for me to enter the following comments.

As Mr. Tullis stated, the membership of the Kentucky Psychiatric Association, one of the co-sponsors of the original survey, discredited the final document by refusing to endorse it. In addition, a doctoral candidate at the University of Kentucky, intrigued by noticeable gaps in the final survey document, developed a rather intensive study of the manner in which the document presented as the final survey report was prepared, as part of her course work under the supervision of a professor on the graduate staff of the university.

The professor wrote in her introduction to the student's analysis of the survey: "This study clearly shows that the findings of the Urban Studies Center[1] were not reported accurately in the Survey (the final published report). Thus, the membership of the Association, as well as the citizens of Kentucky, had misinformation on which to base their decisions about the mental health programs they would or would not support."

This observation speaks for itself. The recommendation concerning the Commission which appeared in the final Survey was the work of a small hand-picked committee and had little relationship to the Survey itself.

It has been noted that Kentucky has completed its network of comprehensive centers, giving coverage to the entire state. Development of such a broad spectrum of services, recruitment of major professional personnel and establishment of a system of record keeping and accountability has been done in a few years with almost a remarkable lack of major crisis. There have been a few, however, that obscure the daily successes of citizen boards and staffs they employ. There is much yet to be done, but we are confident that we have a flexible system that will grow and flourish.

Kentucky's problems with one of the 22 centers—that of the Barren River Comprehensive Care Center which covers the Glasgow/Bowling Green area in western Kentucky—have been much publicized, and I am sure is known to this committee.

I believe the committee has received the report of the special investigator, Mr. William Druhan, who was assigned to Kentucky by the House Committee on Interstate and Foreign Commerce, to study first-hand the audit reports, accounting records and present status of the Barren River Comprehensive Care Center.

As Mr. Druhan can corroborate, the Department opened all books and records, as did the center staff, to his inspection. I, of course, have not seen Mr. Druhan's report but I believe that I can say truthfully that the Barren River program is now fiscally sound and that program development is taking place at a healthy growth rate. Staff morale is now at a much higher level, internal auditing procedures and controls have been firmly established, and all aspects of the Kentucky community program—services covering mental illness, developmental disabilities, alcohol and drug abuse—are now being offered or developed.

One other failure in the system has recently been recorded in the press—and in testimony before this Committee—that of the Crisis Center in Louisville. I am enclosing copies of several articles in *The Courier-Journal* which instigated the initial critical article which indicate the steps taken by the staff to correct the failure in its system.

The fact that the Crisis Center had served more than 30,000 persons last year and that in the month of March, 3670 callers were cared for was not mentioned in the testimony before this committee, although mention of this did appear in the critical newspaper report. The staff and director of the Louisville center concerned have made extensive evaluations of the problems involved to the extent that *The Courier-Journal* has written a laudatory editorial concerning the non-defensive attitude of the center leadership and the steps they are taking to prevent a recurrence.

I would like to directly address the statement by Mr. Tullis in his testimony before the subcommittee that there has been a de-emphasis of the state hospital program.

All of the four state psychiatric hospitals have been accredited and re-accredited by the Joint Commission on Hospital Accreditation for the first time in Kentucky's history, since the development of the community mental health center

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[1] (NOTE.—the original researchers with whom the Mental Health Association and Psychiatric Association contracted and who actually conducted the survey itself.)

program, which began in Kentucky shortly after I assumed the position of Commissioner in 1965. This hardly appears to be a diminution of quality.

There has been, in fact, an integration of the state hospital program into the total circle of services which includes community mental health centers, the private hospitals referred to in our previous testimony, halfway houses, alternative care homes provided by the private sector and a host of others to provide a full spectrum of comprehensive services for the mentally disabled of Kentucky.

While the hospital population has diminished, the staff has remained at the same level, thus providing a realistic ratio of staff/patient coverage. The hospitals no longer are the prime decision makers and the only recourse for those who are mentally ill. If that is de-emphasis, then that is in accordance with the goals of the community mental health program.

As members of the subcommittee implied in their questioning of the witness, it is quite difficult to believe that a state now in the process of reorganzation for greater coordination of human resource services and a department which has not only provided the leadership for the first complete network of mental health centers in the program and which has brought its own facilities from low levels to highly respected and accredited levels of treatment, cannot regulate or judge the efficacy of a system of services for the citizens that we have sworn to assist.

I deeply appreciate the opportunity you have given me to appear before this most knowledgeable and concerned committee.

[Courier Journal, May 16, 1973]

A Forthright Approach to Failure

When a reporter tested the effectiveness of the agency that offers to help you "build a life you can live with" by posing as a potential suicide, Louisville's River Region system broke down. But the aftermath was a kind of vindication.

After the reporter called the mental health agency's Crisis Center, it will be recalled, 3½ days elapsed before he got face-to-face help from an interested counselor. For a truly suicidal personality, the experience could have been fatal.

When River Region authorities were told what had happened, several defenses must have occurred to them: Perhaps the reporter's pose wasn't convincing. The whole thing was sneaky. Or, one breakdown doesn't indict a whole system.

Instead, the River Region executive director, Del Combs, met the questions head-on. Then he ordered a thorough study, and Medical Director Alfred Chatman suggested changes in procedure.

At a public meeting, the River Region's board of citizen directors was told the facts. At present, Mr. Combs conceded, the same thing could happen again. Yet, by not taking a hostile and defensive stand, River Region showed real concern for service in the areas for which the agency is responsible: mental health, retardation, alcoholism and drug abuse.

The incident is one that other public officials and agencies could meditate on.

[Courier-Journal May 10, 1973]

Study Suggests Crisis Center Improvements

(By Chris Waddle, Conrier-Journal Staff Writer)

A continuing staff investigation into the handling of crisis situations by the River Region Mental Health-Mental Retardation Board already shows eight recommendations toward improving the board's 24-hour Crisis and Information Center and neighborhood mental health centers.

Among the recommendations announced last night are: face-to-face interviews with clients in the event of any life-threatening episode, improved communication between River Region's different offices, and preparedness by the agency's staff to provide crisis intervention services whenever they are needed.

The internal investigation was launched by the board's executive director, Del Combs, the day after an April 22 story in The Courier-Journal & Times revealed it took a reporter—posing as a potential suicide—3½ days to make personal contact with someone in the agency responsible for dealing with such cases.

The Courier-Journal reporter twice failed to get face-to-face evaluations, was sent to a neighborhood center that turned out to be closed, and on a later visit to the center waited some time before a receptionist told him no counselor could see him.

Combs said in an interview yesterday the series of events was a "comedy of errors." But he said the agency is trying to deal with the problem in an honest way to see that such a thing does not happen again.

"If we are honest," he added, "we would have to say it could happen again."

The official said he had ordered questionnaires sent to every component of River Region to see if staff members thought their offices could commit goofs similar to those the reporter encountered.

Not all the answers are back yet, but some mental health workers thought it's possible the series of events could recur in almost all of the 13 neighborhood mental health centers in the agency.

Communication among River Region's components is one of the main problems, according to a report prepared by Dr. Alfred L. Chatman, medical director for the agency.

The report said interviews with the principal River Region employes involved in the newspaper investigation revealed the workers doubted the degree of suicidal risk in the patient portrayed by the reporter.

But the official's report cited seven different errors on the part of the agency in the case of the reporter's portrayal, which was made with no warning to River Region.

Chatman listed the mistakes as the referring of a client to a closed clinic with no alternative procedure for him to follow, the fact that his name was not referred to the neighborhood center, the lack of a personal interview to assess the intensity of the suicide threat and problems in the neighborhood center's waiting room.

More recommendations for improving on the problem areas are expected to be presented to River Region's next board meeting. But the eight that have been made so far—with immediate distribution of them to River Region's different components—are listed in Chatman's report. In brief, they are:

No office in the far-flung mental health agency should be completely closed during regular working hours. Or if closing is absolutely necessary, alternative courses of action for clients should be presented.

An in-service training program of analyzing the handling of crisis calls should be expanded in the Crisis Center and introduced in all units of River Region. Emphasis should be on dealing with life-threatening emergencies and other severe impact situations.

Staff should be rotated among the different service centers of River Region so they can understand the importance of communicating with each other about patients. Reception areas in the centers should be improved so that a client can't come into one without getting immediate attention.

Assumption should not be made about the emergency nature of a client's problem. Inquiry should be made to determine if immediate attention is needed before cases are given routine appointments.

In the case of life-threatening episodes, "error must be made in the direction of doing too much rather than run the risk of doing too little." If possible, such cases should result in face-to-face interviews by a professionally trained person. If any question exists about risk, a physician who has the ultimate medical responsibility should be brought in.

Receptionists should be free from duties that keep them from making immediate contact with persons who come into their centers.

Every center should be able to borrow personnel from other centers if necessary to deal with a crisis situation.

Every service unit of the mental health agency should have the immediate capability of dealing with clients regardless of previously scheduled appointments, meetings or lunch breaks.

"We should assume within all of our service areas that we are operating an emergency service and have no way of predicting when or what emergency will strike next," Chatman's report says.

"This is a fact in our work, and we must be able to react immediately and decisively to any problem as it presents itself to us."

Combs, the executive director of River Region, told board members yesterday that the agency is not being defensive about the newspaper's findings.

And he noted the article reported River Region's official view that what the reporter experienced in his pretend-suicide case was not considered typical.

"But obviously we have some gaps there," Combs said, "and we are moving to close them."

Combs said he welcomed the role of the press in pointing out holes in River Region's services "because we want to do our best."

[Shelby News-Sentinel, May 8, 1973]

CRISIS CENTER WORKS

If customer satisfaction is an accurate barometer of success, then personnel of the River Region Crisis and Information Center can now be assured that the many long hours spent on the telephone helping people with their problems is appreciated.

The center has just compiled the results from a recent telephone questionnaire sampling of 100 randomly selected former clients.

The clients were asked to answer either "yes," "somewhat" or "no" to each of four questions selected to guage the centers effectiveness.

Following are the questions and results:

Did you feel the people you talked to at the Crisis and Information Center were interested in helping you with your problem? Yes, 87 percent; somewhat 7 percent; no, 6 percent.

Did you get the help you wanted? Yes, 71 percent; somewhat, 24 percent, no, 5 percent.

Now that you have used our services, if you needed help again, would you be likely to call us? Yes, 90 percent; somewhat, 6 percent; no, 4 percent.

Would you recommend our service to a friend? Yes, 94 percent; somewhat, 4 percent; no, 2 percent.

The center handled 27,000 calls during its first year, 30,000 last year, and anticipates handling at least 36,000 this year.

In March, 3,670 calls were received at the center, including 72 that were suicide related.

Calls can be made toll free from anywhere in the River Region service area: Jefferson, Oldham, Shelby, Henry, Trimble, Bullitt and Spencer counties.

Two numbers ring into the center: 589–4313, the HELP line for problems of a general nature, and 589–4470, the Hair (Help Always In Reach) line for youth-oriented problems.

River Region operates the center and funds it jointly with Metro United Way.

Mr. ROGERS. This concludes our hearings of today.

[Whereupon, at 3:15 p.m. the subcommittee adjourned at the call of the chair.]

COMMUNITY MENTAL HEALTH CENTERS—OVERSIGHT

FRIDAY, JUNE 15, 1973

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
New York, N.Y.

The subcommittee met at 9 a.m., pursuant to notice, in the Mercury Rotunda, New York Hilton Hotel, Avenue of the Americas and 53d Street, New York, N.Y., Hon. James Symington presiding [Hon. Paul G. Rogers, chairman].

Mr. SYMINGTON. Good morning, ladies and gentlemen.

With your indulgence, we will begin the proceedings.

I regret very much to say what I think some of you already know. Congressman Hastings and I, Congressman Symington, have to leave to catch a plane in a little over an hour in order to cast some votes which we did not know would happen when we originally scheduled this meeting.

I would like at this time to formally open this, the second oversight hearing on community mental health centers.

I am sure everyone here knows that the administration has proposed termination of assistance to new centers, whereas the 1974 extension bill continues for 1 year the community mental health services program and that bill is actually on the President's desk and it is our fervent hope that he will sign it.

We know, contrary to the testimony that has been received from spokesmen of this administration, that community mental health centers are not just demonstration projects and were not really intended to be demonstration projects.

They were intended to be established and to go into operation and remain so. I think the additional figure was some 1,500 centers, of which there are now only 325 in operation.

I think that our meeting this morning ought to convey to the community that you represent and to the Congress the interest of New York.

I must say in that connection that we are here at the behest of Congressman James Hastings of New York who secured the permission of the Chairman, Paul Rogers of the Subcommittee on Public Health and Environment of the Committee on Interstate and Foreign Commerce, to come here and take your testimony.

Although Mr. Hastings and I do have to leave around 10:30, it is our decision, with the chairman's permission, to allow the record to remain open after we close the formal part of the hearings and the stenotype reporter will remain here and for one of you, perhaps the

Commissioner, to conduct discussions perhaps as a panel as you might deem warranted and then we will incorporate those observations, comments and discussions into the complete record before we close it.

Before introducing the witnesses, I wonder if Mr. Hastings would like to make a comment at this time.

Mr. HASTINGS. Thank you, Mr. Chairman.

First I would like to thank you on behalf of Chairman Rogers for coming to New York with me. Chairman Paul Rogers expressed his regret at not being able to be here.

He has a great interest in community mental health centers and I think as a result of our committee's work we will have permanent community health centers.

This morning, members of the House Subcommittee on Public Health and Environment are holding oversight hearings on the future of the Community Mental Health Centers Act. On May 31, the House—by a vote of 372 to 1—passed and sent to the President my Health Programs Extension bill. This legislation would extend the Community Mental Health Centers Act one more year, along with 11 other Federal health programs. We on the subcommittee hope the President signs the bill, to give us time for proper study and evaluation.

The subcommittee is agreed that the community mental health centers program was not intended to be a mere "demonstration program," as assumed by some members of the administration. On the other hand, the program was never intended to be used as a permanent source of financial support. It was intended that all centers be operated eventually without direct Federal assistance.

Our subcommittee is currently exploring a decentralized, regional approach to health care for the Nation, within a framework of special revenue sharing and some form of national health insurance. We view the Community Mental Health Centers Act as an early leader in the regional approach to health care delivery. This morning, we will be most interested in suggestions from the witnesses as to how community mental health centers can be improved and how a full complement of 1,500 such centers can fit into a decentralized system of funding.

I would only say in clarification of where we stand today that, as Mr. Symington pointed out, the administration scheduled termination of the community mental health centers program as of June 30.

A 1-year extension, by means of H.R. 7806, was passed with the cosponsorship of Mr. Symington and myself and many other others in the Congress. It passed by a vote of 372 to 1 and it is awaiting passage in the Senate.

This hearing today will be part of the consideration of what type of mental health program will exist in permanent statute.

So, it is of extreme importance what develops in this hearing and subsequent hearings which will be held in Washington.

We appreciate very much the fact that you will help us to build a record to help pass some permanent form of legislation.

Because of the time limitations, I will turn the hearing back to the chairman so that we can proceed.

Mr. SYMINGTON. Thank you, Mr. Hastings.

First, I would like to determine if we have present the witnesses whose testimony will become part of the record today:

Mr. Irving Blumberg, executive director of the New York Citizens Against Mental Illness.

Why don't you take the chair, sir, because you will be the first witness.

We will also be hearing today from Commissioner Miller, Commissioner Christmas, Reverend Hutchinson, and Dr. Campbell. Also, Mr. Schneier, Dr. Paster, Dr. Hart, Mr. Cooper, and Mrs. Sabino, who I met earlier.

My suggestion is that the witnesses try to restrict their verbal testimony to the bare essentials of what we must know, recognizing that their full statements, written statements, will be made part of the record in any event.

With that, we will begin by welcoming Mr. Irving Blumberg, executive director of New York Citizens Against Mental Illness.

It is very kind of you to be with us today and we look forward to your testimony.

STATEMENT OF IRVING BLUMBERG, EXECUTIVE DIRECTOR, NEW YORK CITIZENS AGAINST MENTAL ILLNESS

Mr. BLUMBERG. Thank you, Mr. Chairman and Mr. Hastings.

My name is Irving Blumberg and I am the executive director of the Citizens Against Mental Illness.

First may I express our gratification at the forthright action of the Congress—the House and the Senate—in reasserting its legislative prerogative by overwhelmingly repassing the legislation continuing community mental health center programs and other essential health programs.

More particularly, I would like to express our deep appreciation and gratitude to you, Congressman Symington, and you, Congressman Hastings, from our own State of New York, for exercising initiative, courage, and leadership in sponsoring this legislation now awaiting the President's action.

Your sponsorship and that of many other Republicans and Democrats exemplifies the nonpartisan nature of this measure which so vitally affects the health of millions of Americans throughout the land.

The reenactment of the health legislation earlier vetoed by the President goes to the heart of the issue of continued Federal responsibility for the health of the American people.

The administration cannot and must not be allowed to dictate legislative and fiscal authority over Congress. The Congress should not and the concurrent actions of both Houses have so signified, decide to absolve the Federal Government of substantial co-responsibility, with State and local governments and the private sector, in assuring adequate and humane levels of service to meet the health, education, and welfare needs of all of the people.

We fully recognize that what is here at issue is not simply the continued existence and expansion of community mental health centers desirable as this may be.

Also involved is the need for strengthening the integration of center services with other equally important subsystems of local mental health service delivery systems, however funded, and by whomever administered.

We must strive, I feel, to develop a truly comprehensive, effective, and continuous interrelated system of health care for those who need such health care wherever they live and whatever their social and economic status.

Hopefully therefore these hearings and the discussions to follow will lead us to work in a spirit of partnership and cooperation which will assure that high quality services, particularly rehabilitative services, will be made available and accessible even to our least advantaged and most vulnerable fellow citizens.

Thank you very much.

Mr. SYMINGTON. I thank you very much for your statement for both its content and its brevity.

With the permission of the witnesses, I would like to establish my own schedule of witnesses here which may not be precisely in accordance with the schedule some of you have at this time and I would like to call on Commissioner Alan Miller, Commissioner of Mental Hygiene for the State of New York.

We are very glad to have you with us today.

STATEMENT OF DR. ALAN D. MILLER, COMMISSIONER, NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE

Dr. MILLER. Many thanks for holding the hearing and for inviting me.

I echo Irving Blumberg's remarks about the leadership the Congress has exercised and our gratitude for your being here. I personally feel proud as a New Yorker that among you is Congressman Hastings.

I have a written statement which, with your permission, I will not read, but which I would like to have made a part of the record.

Mr. SYMINGTON. It is so ordered. [See p. 120].

Dr. MILLER. In my statement, I do describe briefly something of the impact that the community mental health centers program has had in New York, what impacts it ought to have in the future and, in short, my reasons for thinking that it should grow.

I would like to depart from my written testimony to talk briefly and even personally and perhaps autobiographically—in part to establish my credentials, which sounds too formal—and about my relationship to this program, which I think has given me a chance to see it to, observe it, and to be an actual part of it, which is a fairly unusual experience.

I was on the staff of NIMH in the early 1960's. Those were exciting days when the Congress and the Executive were trying to put to work an enormous new surge of energy and concern for the mentally disabled and to find new instruments, new governmental and voluntary instruments, for bringing an unprecedented level of concern for and response to the problems of the mentally disabled.

In that exciting era—I was in charge of field operations at the time—a number of programs were born. Some of them were intended to be short lived. These included (1) a comprehensive mental health and retardation planning effort, which produced in every State a new involvement of thousands and thousands of citizens in thinking through the problems of their own States; (2) the hospital improvement programs which were, I think, unfortunately short lived; and

(3) the comprehensive community mental health services program and the retardation facilities program.

They all represented a kind of federalism, a federalism which I regard as the most healthy kind. They were not Federal programs that made State and local programs something less. They were strong Federal programs based on the assumption that strong Federal programs of a certain character would in fact stimulate and make possible local growth initiative and competency in every community in the country.

That was their thrust and that has been their consequence.

In 1964, I came to New York. I was in charge of a community program and had a chance at that time in that capacity to see how this new legislation could really make a difference.

Even in a State which had already made strong commitments and developed deep involvements in community mental health programs, this act became—to use the overworked term, but most appropriately here—became a catalyst. It was not a reward for good intentions. This was an opportunity for the development at the State level, as well as at every county level and for every population group, of a response to the needs and desires of citizens naturally grouped, and of the stimulus it provided throughout the State.

It has brought about a qualitatively new kind of development of health services.

There are certain characteristics of the community mental health and retardation services programs which to my knowledge make them unique among Federal health legislation.

Their focus throughout has been on working with whole populations, with natural geographically defined populations. These programs were not designed to select special clientele according to a number of restrictive criteria, but were rather designed to respond to the full range of needs of an entire population and to work with it and to find ways to do so.

That unique approach, that focus on whole populations, I think, has been the essence and the strength of the community mental health program as we have seen it grow in many States and localities.

For the last 4 years I have been a member of the National Advisory Mental Health Control and in that capacity I have examined, analyzed and finally approved every application for a mental health center that came before the HEW.

I have thus had a chance to see the same kind of experience in every part of the country. Every center is not a static phenomenon. It is the result of a process and it is itself the beginning of a process. Every center has created a living entity in each site where it is located.

This dynamic movement has given each community that has applied it an opportunity to hammer out natural workways for itself. That is why I think it would be important to enable this kind of effort to begin and to grow in all the many areas of the country, this State included, which have not yet had the same kind of support from a Federal program which not only has provided necessary and critical funds but has also carried with it the high level of leadership that only the Federal Government can provide for an idea whose time is long past.

These are some of the reasons why I think, Congressmen, that we are dealing with a matter of crucial importance. We are dealing with more than a matter of trying to decide how funds should be provided. We are dealing with a much more fundamental matter: Namely, how do we meet our responsibility to mentally disabled people.

The mental health program was not intended to be wholly dependent upon Federal funds. Federal funds made it possible to begin something, often in impoverished areas with special groups of vulnerable people who would not have been able to start such programs when they did.

If you look at the experience in New York and every other State, you will find that the funds provided by the State and by local, public and voluntary resources have far exceeded the Federal funds. But what cannot be measured, even proportionately, is the opportunity which this program has provided for something to grow in each new place in a way which was appropriate to it for us in New York, and I can only speak now for New York as its commissioner of mental hygiene.

We think we have made a good start in this process.

We have just adopted some interesting and important legislation, called unified services, which makes it possible for us to join the State and local capacities in every county and city in New York.

The community mental health program would greatly help us continue this essential work.

I thank you for your patience and for coming to New York and we wish you well.

[Dr. Miller's prepared statement follows:]

STATEMENT OF ALAN D. MILLER, M.D., COMMISSIONER NEW YORK STATE DEPARTMENT OF MENTAL HYOIENE

I am Alan D. Miller, Commissioner of Mental Hygiene of the State of New York. I am most concerned to see the maintenance of the Federal Government's effort in the provision of Community Mental Health Services.

In New York we have reduced the average daily inpatient population of state hospitals from a peak level of 93,000 to a little over 41,000. Although this reduction is the result of a number of factors, a significant one is the provision of adequate treatment in local community facilities. It has been amply demonstrated that a well functioning community health service can make a significant impact on admission rates and more importantly resident patient rates in state hospitals. Since the care of the long term state hospitalized patient represents a tremendous expenditure of public money, continuation and expansion of the mental health center program is fiscally sound.

The saving in human distress and the elimination of the personally damaging effects of long term hospitalization in remote impersonal institutions are, of course, too well known to require further description by me.

It seems strange that on the one hand the Department of Health, Education, and Welfare, through the Developmental Disabilities Services Act, is making specific grants to states to help plan for deinstitutionalization of the mentally retarded but on the other is threatening to extinguish the Community Mental Health Center program, which has the potential to be a great force for deinstitutionalization of the mentally ill.

Since the Community Mental Health Center program started, New York State has built, or has in process of development, 26 mental health centers at a total cost of $98,855,000. Of this amount, $15,622,000, or 15.7 percent represents the Federal share of costs. Thus, a relatively small investment of federal dollars generates considerable resources from the state communities. Furthermore, the success of the concept has allowed us to develop three community mental health centers without any construction costs, using existing buildings in a variety of imaginative ways.

There are cnrrently expressions of intent from six commnnities wishing to engage in construction of community mental health centers. Whlie it is as yet uncertain how many of these will be developed in the absence of federal support, I know that this source of fundlng often makes the difference between a go or a no go situation. This is particularly true in poverty areas where the potential for voluntary agency or local governmental participation is small.

Of conrse, construction, though important, is not the only part of the community mental health center program whlch concerns me. It has been our experience in New York that gross annual operational costs for a center run at about one-third the capital cost.

For the year ending March 1973, the Federal Government gave to centers in this state $10,823,245 in staffing grants; state and local funds from various sources accounted for jnst over an additional $20 million. There have, however, been several community mental health centers in this state built with federal aid whlch have not received staffing grants. For exampie, Buffaio General Hospital and Arden Hill Hospital in Orange County both have newiy built community mental health centers. Their staffing grant applications have been approved, but not funded. Brookdale Hospital with a mental health center in operation sought additional funds for an expansion of its catchment area. Again, the appiication was approved, bnt not funded.

Now, it is true that all these centers, by imaginative use of staff and by staff sharing with other facilities, have begun to develop programs. In Buffaio where the mental health center director is also the director of Buffalo State Hospitai—many of the staff move freely between state hospital and community mental health center programs, unhampered by questions of whose payroll they may be on. This makes for sound program development and particniariy for continuity of care, a point stressed very strongiy by the federal regulations.

However, with no federal assistance the program operators are bound to move their services in directions where third party payments can be made.

Although I snbscribe to the view that, whenever possible, mental health programs should be funded in the same manner as generic health services, there are some unique problems. In general, health services are paid for on a fee for service model throngh private or governmental insurance. Most fee for service programs are geared to tradltional in-hospitai care—the most expensive way of providing treatment to psychiatric patients. Few third party payors cover partial hospitallzation, and such payment processes never cover the vitally important area of prevention. Since the Federal Government rightly mandates, through the consultation and edncation element of center programs, a preventive approach, it makes little sense to be advised to seek third party payments. Unless and until we have a universal health insurance program which covers the area of prevention as weii as treatment, direct governmental support of staff carrying out these functions is essential.

Another particular of the federal program which potentially is most nseful is the provision for providing specialized services within mental health centers for children, for aicoholics, and for other special groups. The problems of providing third party payments for many of the services that these kinds of clients require are similar to those I've just outlined in regard to preventive services.

The single most important value of the mental health center program has been its focus on the need for population-based services. The concept of providing services on the basis of total population needs in an area has been a powerfui tool in overcoming some of the problems inherent in the kinds of discriminatory selection of patients that all service providers are prone to, that is, to serve the interesting case or the non-troublesome case. It has also provided a basis for the systematic study of an area to insure tbat consideration is given to all of the services needed by the population in that area.

We have used these concepts in new legislation in New York State which Governor Nelson A. Rockefeiler signed on Tuesday, June 12. It provides for a unified system of mental health, mental retardation and alcoholism services jointly planned and delivered by state and local government in partnership with voiuntary and private agencies. There are requirements for strong integrated planning efforts requiring a participation of consumers as well as providers in these efforts, and a strong requirement for effective evaluation and measurement of program effectiveness. The continuation of the Federal Community Mental Health Center program will be of great assistance to us in implementing our plan for the development for a unified system of services within New York State.

I would like to take this opportunity to make known to you a major concern I have about what seems to be the proposed direction of the Federal Government in regard to the support of health manpower training. The recommendations contained in the Administration's proposed budget for 1974 will substantially reduce the level of funds available for the support of training grants, research fellowships and research scientist development activities of the National Institue of Mental Health, of the Health Resources Administration, and of the Social and Rehabilitation Services Agency. I believe this to be a very shortsighted approach to the future needs of this country for the development of the kinds of services which are needed by our citizens, particularly in urban poverty areas and underdeveloped rural areas.

The shortages of health manpower continue to be a major obstacle to the development of adequate health services. We find this to be particularly true in providing services for the mentally disabled. If we do not continue to invest money in training, we will find ourselves with a generation gap in the development of health professionals and paraprofessionals, and we will have in the future an even greater problem than we have had in the past in regard to the number of trained people available to render preventive, treatment and rehabilitation services. I would urge you to scrutinize the budget for training purposes carefully and hope that you will be able to assure yourselves that it will provide sufficient funds to insure that we will continue to have an ample supply of health manpower for services and, at least as important, for research.

Mr. SYMINGTON. Thank you very much.

You mentioned a new State law. Are there improvements in Federal legislation that you would recommend at this time or just further emphasis on what we are already doing?

Dr. MILLER. I have always thought that the heart of the mental health centers legislation has not been—although the concept is important and had to be emphasized early—the so-called five essential services: inpatient care, partial hospitalization, emergency care, outpatient care, and consultation and education.

There was, as I said, a great deal of emphasis on these essential services. They were important because their inclusion reflected the recognition that every population requires a full range of essential mental health services.

I think the heart of the center program, however, was not the five essentials as such but the idea, the concept, of a single focus of responsibility. There had to be a "living" organism that had to have the ability to assess its needs and have a program to provide all the needed services.

As to improvements, there are certain needed flexibilities and I propose them cautiously because, as you can see, for personal as well as professional reasons, I regard the program as a precious piece of legislation.

I think, for example, that it might be possible in some areas to support a center whose major thrust was not residential care—as long as there were adequate provisions for residential services—but other forms of services some of which we may not be able to conceive of today.

Various day services and partial hospitalization services are part of the total mental health program, but in some areas they will be all that is really needed to fill out the program.

These are services which today are virtually never covered by third-party payments. It is difficut to get adequate financing for such services.

I think that these forms of services might be modified. I think there are various ways of considering their formula, their duration, and their structure; but I won't go into them now.

There is one thing that I feel very stongly: The emphasis of the recent changes within the last several years, which made it even more possible for community mental health programs to begin in areas which were poorest in resources, should be continued and strengthened.

Any governmental program should be designed not simply to reinforce strengths but also to move capacities where there is now too much weakness for strengths to develop.

That is federalism at its best. We might make even stronger efforts to support programs in impoverished areas.

I would like, if you would permit me, the privilege of reflecting further on that important question. It is too important to give a quick answer.

Mr. SYMINGTON. You may prepare a memorandum on that and we will make it a part of the record.

[The following letter and attachment were received for the record:]

NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE,
OFFICE OF THE COMMISSIONER,
New York, N.Y., July 10, 1973.

Hon. JAMES F. HASTINGS,
Congress of the United States,
Cannon Office Building, Washington, D.C.

DEAR CONGRESSMAN HASTINGS: Dr. Miller tells me that at a meeting with you you asked him to prepare some recommendations for possible changes in the Community Mental Health Centers legislation. Following up on your request Dr. Miller called a meeting of eight people closely involved in mental health center planning and development in this State.

I enclose a summary of points made at the meeting which I hope will be of help to you in your further deliberations.

Sincerely yours,

ANTHONY SPELLMAN, M.D.,
Deputy Commissioner.

Attachment.

JULY 9, 1973.

MEETING OF JULY 3 ON COMMUNITY MENTAL HEALTH CENTERS

The following is a condensed version of notes taken by Dr. Spellman and myself during the July 3rd meeting on Community Mental Health Centers. I have found it useful to group the various ideas expressed by the participants in the following manner:

A. FUNDING

1. General.—There seemed to be general agreement that there should be a longer commitment by the federal government for funding of community mental health centers. Particular concern was expressed for the future of centers funded at the poverty level and a suggestion was offered to reduce the federal funding level for these centers by not more than 10% per year in order to allow them adequate time to develop alternative sources of revenue.

There was also a recommendation that the federal government provide support for the entire program rather than for staffing costs only.

2. There was concurrence on the need for continuing federal support of those program areas which are unlikely to attract support from 3rd party funding mechanisms, such as consultation and education, training, community organization activities, etc. (see also Congressman Roy's bill).

3. Start-up costs of new centers should continue to be supported by the Federal Government, regardless of other reimbursement mechanisms that may be developed.

4. There was less concern than expected about the gross discrepancies in funding levels of different catchment areas. However, there was agreement that a high level of funding does not necessarily mean a high quality program. The problem requires further study and perhaps new legislation could require NIMH to conduct such a study and develop guidelines to determine the range within which operational costs should be kept.

B. COMMUNITY MENTAL HEALTH CENTER CONCEPTS

1. Catchment areas.—The catchment area concept was considered to be basically sound but in need of revivision of its operational definition to remove some of the rigidity which has crept in. No specific recommendation was made by the group; however, after the meeting, I saw Congressman Roy's bill which contains a new definition deserving of careful study.

2. Essential services should be continued as a basic requirement, possibly with the addition of pre-care and aftercare. The majority seemed to feel that, particularly in poverty areas, there should be more flexibility for phase-in—*not* requiring 3 of 5 services immediately—including inpatient—and allowing more than 18 months for phase-in.

3. System building.—Much discussion focused on a stronger legislative mandate to total systems of care:

Formal integration of all health components in each area—the Federal government would contract for a total service system.

Tightening up of agreements with state hospitals—need for centers to increase their sense of responsibility for the severely or chronically ill. (We probably have a fairly good handle on this in New York by insisting that the written agreement preclude transfer to a state hospital on the basis of length of inpatient stay alone. Perhaps this should be built into federal regulations, if not the law.)

The name of the Act might be changed to "Mental Health Services Systems Act".

A comprehensive mental health plan should be mandated in lieu of the present State Plan for construction of community mental health centers.

4. Community control.—New legislation ought to mandate real community control. A great deal of thought will be required to identify clearly what is meant by this term. At a minimum it should mean control by a representative community group which addresses itself to the total needs of the community rather than control by a group such as a hospital board with more parochial interests relating to a particular agency.

C. POLICING AND EVALUATION

1. The federal government needs effective power to police centers or should provide the various states with the means of policing them. The legislative mandate to do so must be reinforced by appropriate line item appropriation.

2. There is need for much better evaluation of programs both internal and external with the ability of federal (and state) governments to make changes in program direction as needed rather than merely monitoring compliance with the original application. The grantee himself should be required to make appropriate changes in his program in response to changing needs of the community served or to new discoveries and techniques in the professional field.

3. The contract between the federal government and the center should be in relation to specific program objectives. This would make possible a meaningful system of accountability.

4. There should be a graduated response to non-compliance. The limited alternatives open to DHEW Regional Office staff often prevent effective action to force centers into a state of compliance. Total suspension of funds is an unpalatable alternative because it means that people in need will have to go without services. A more appropriate response would be a partial withholding of funds until the deficiency has been corrected.

Mr. HASTINGS. I would like to acknowledge your leadership in the State of New York. Having served in the State legislature from 1962 to 1968 while you were actively developing the system of mental health centers in the State of New York, I was very much aware of your contribution.

I have a couple of questions, but time won't allow us to discuss these as fully as we should. Hopefully at a subsequent period we can.

Our figures indicate that of the persons served by community mental health centers throughout the country, 64 percent are below $5,000 income level, which would seem to indicate that the larger share does go to the impoverished in this country.

At the same time figures seem to indicate that medicaid and medicare only proved 6 percent of the total fund paid into CMHC.

First, with that number people at the poverty level served, why isn't the medicaid a more significant factor in relation to the source of funding?

Is there some rational reasoning for this which you could tell the committee?

Dr. MILLER. I regret I can't. I don't believe that would be our experience in New York.

Mr. HASTINGS. I would repeat, of course, these are nationwide figures.

Dr. MILLER. It would be hard for me to answer.

Mr. HASTINGS. Could you provide the New York State figures reflecting what is our experience in the city of New York?

Dr. MILLER. Yes, I can do that.

[The information requested was not available to the committee at the time of printing.]

Mr. HASTINGS. Since medicare is only a small part of the 6 percent which includes both medicare and medicaid, does this reflect that community mental health centers are not serving enough elderly people?

Dr. MILLER. That would be a reasonable assumption. It has been a nationwide experience, I think that other than at certain public residential, or State hospital programs, the elderly have long been grossly underserved.

Mr. HASTINGS. Do you thing we should put some emphasis on these areas in future legislation?

Dr. MILLER. I think that would be salutary.

Mr. HASTINGS. In the rural areas of this State, of which my district is a part, and of the country, is the 75,000 minimum population figure for a catchment area a limiting factor to the viability of community mental health centers in rural areas?

Dr. MILLER. I think it probably has been, but it need not have been.

It was said even in the early days of the program that if there was any reasonable evidence which showed that these limits were inappropriate, they should be closely looked at and reconsidered. In some instances they have been; but perhaps in too many instances, they may not have been.

I think it was important when the bill was passed and I still think it is important, that these programs seemed to be the kind that were simply not going to be able to select populations for their convenience.

In doing so, some rural areas on one end of the scale and some highly organized metropolitan areas on the other may have felt the inappropriate pinch of a regulation.

I don't know whether lowering it from 75 to 50 would solve the problem, because there would then be some at 45 that would be appropriate.

I think it is important to stress the fact that a valid application that differed from those limits should be considered on its merits.

Mr. HASTINGS. If the Secretary of HEW had the flexibility of improving an area of less than 75,000——

Dr. MILLER. I think that would be helpful.

Mr. HASTINGS. I have many, many other questions and I hope that we will have a further opportunity to discuss these questions with you when we have further hearings in Washington.

Dr. MILLER. Thank you very much, and I will send you a memorandum on those other questions.

Mr. SYMINGTON. Thank you very much.

At this time we will be pleased to hear from Commissioner June Christmas of the New York City Department of Mental Health.

STATEMENT OF DR. JUNE J. CHRISTMAS, COMMISSIONER, DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION SERVICES, NEW YORK CITY

Dr. CHRISTMAS. Mr. Symington and Mr. Hastings, I wish to thank the committee for the opportunity to speak before you today. I will request that my prepared statement, from which I shall present some remarks, be placed in the record. Primarily, I would like to share with you the experience we have had in New York City with community mental health centers, specifically those federally funded and let you know our recommendations for community mental health services in the future.

New York City Community Mental Health Centers, utilizing Federal funding, are operating in only 6 out of 49 catchment areas. Two other centers not receiving Federal funds follow the Federal guidelines.

The total budget for mental health, mental retardation and alcoholism services in New York City, exclusive of the State system, is $170 million. Total Federal input is $26 million, of which only $8 million is in community mental health centers. The bulk of Federal aid comes through medicaid, and amounts to $18 million. Total Federal, State, and city money for community mental health centers in 1972–73 is $20 million. Thus Public Law 88–164 today funds less than 50 percent of total CMHC funding, less than one-twentieth of the overall city budget. Even in construction the amount of Federal input has been small; yet the effect of Federal legislation has been immense.

If we look at what this has accomplished, I think we may begin to raise questions as to where we should be going in the future.

What has Federal money accomplished? Have we approached the goals of community involvement and participation in decisionmaking of comprehensiveness and continuity of care, of diminishing the role of the State hospital? Are services traditional or innovative? Have the principles of community mental health been extended, along a public health model, to a designated population? Have we moved appreciably toward meeting needs? I would say that experiences in New York, while not typical, even of large cities, because of a relative abundance of services for some, illustrate a few of the results experienced nationwide in urban areas.

Certainly there have been successes. Two CMHC's located in the Borough of the Bronx have made it possible to offer services to a deprived population with high indices of need in all areas, a population that virtually lacked locally based mental health services prior to CMHC's.

One of these has worked cooperatively with the State hospital toward an integrated approach to care. On Staten Island, the Borough of Richmond, a CMHC is making possible inpatient care on the island

for the first time and will develop links with local ambulatory care programs. In the Borough of Brooklyn, a CMHC has been a national model for community involvement.

New concepts have been introduced through CMHC legislation requiring community involvement and consultation and education. They have been developed extensively in innovative programs. Even in more traditional centers, initial hesitant steps toward community involvement and community advisory boards and consultation, outreach, and education services—both new to mental health—have now been accepted as almost usual rather than exceptional, not only in CMHC's, but in other programs as well. True, the role of the community remains to be defined; the partnership is still an unsteady one, but the advances have been made in the direction of greater accountability and greater responsiveness.

But, too often, consumer and citizen involvement has been perfunctory tokenism. We are suggesting that we move in a direction toward sponsorship by community corporations, by councils of community-based programs linking networks of services, accountable to and controlled by the local community. This is one direction in which funding and program planning should move.

We realize that we have in jeopardy the one program in New York City, in Washington Heights, which is so structured, and we trust that the imminent situation of near disaster will not really come to pass. We see this as a new direction in which community and providers can work together to provide a different kind of care.

Narrow insistence on a medical model, insufficiently involved with other human services, focused almost exclusively on treatment to the exclusion of rehabilitation and prevention. This approach led to a persistence of traditional approaches in far too many instances. People were excluded in CMHC's as they had been in psychiatric services in the past, because they were too poor, or of racial minorities, or alcoholics, or addicts, or children, or chronically ill, or retarded, or elderly. We think it is of paramount importance that all mentally disabled be included in services.

The prevalent interpretation of the concept of the community mental health center as a structure—as exemplified in the rush to plans and buildings and minidepartments of psychiatry—this narrow concept must be open to question. Somewhere in the past as we all joined the bandwagon, the idea of a comprehensive network of services—of all relevant human services within a defined area—was put aside in favor of the massive applications wending their way to Washington for the far-off program. Now we find ourselves bound to buildings designed to house large numbers of inpatients when the needs of today indicate far more ambulatory care; we are locked into structures which limit our ability to respond to changing program needs.

There has been little innovation in the content of services nor have linkages been developed. The five essential services are the traditional ones.

Education, health, the law, the world of work, are vital systems which are not related to the mental health nonsystem.

In the worst cases, services offered have often borne only a tangential relationship to the needs of an area. In New York City, for example, only three of the six federally funded centers are located in neighbor-

hoods which rank among the top 20 poverty areas, areas which, almost by definition, lack services. With little overall planning and technical assistance from city and State formerly available, well-established institutions were able to develop applications and have them approved. Innovative, community-based and local agencies faced an almost impossible task of competing with the academic or hospital giants, without any assistance from local or Federal Governments.

We must turn this around so that we fulfill our responsibilities.

Evaluation, when carried out, has been limited. Criteria have been related primarily to reductions in numbers of admissions and length of stay in State hospitals.

When we move to the issue of catchment area we see another problem. In New York City we adopted the upper limit of 200,000 persons. Yet, in a large urban area this is too low a figure for services that ought to be provided on a larger base, for example, mental retardation and rehabilitation services. Even some children's services might be provided to a larger population.

Yet the process of getting waivers from Federal standards was restrictive, lengthy, and discouraging. Similar problems in implementation have existed at every level between city and State, between city and Federal governments. Nevertheless, I think that we may hope that with our pushing together that that kind of barrier may be broken down.

Now I want to comment specifically as our recommendations.

Here I am confining my remarks to the needs of a densely populated urban area.

Indeed, one aspect of the original legislation which may be subject to refinement is that of offering one model for rural areas, urbanizing intermediate-sized areas, and for the highly urban areas—communities with distinctive characteristics and needs.

The first is that we move away from the concept of a static physical plant to a dynamic network of services that would be comprehensive, coordinated and truly interdisciplinary. Because the medical model of sickness was used, skills of other disciplines and capabilities of related kinds of service providers were not utilized.

Today we can look toward a network of services planned for each community within the city which can be more easily altered as new needs arise, or old ones attain or lose priority.

In regard to a potential overall planning structure and process, there should be required a statement of community needs and gaps of services as a part of a specific plan of how a local area would meet these needs rather than in the past where, almost on their own, organizations developed programs in helter-skelter fashion. In short, I am saying that the community mental health services should be part of an annual and total planning process that is revised, kept up to date and priorities kept current.

In other words, planning and development of community mental health service programs should be integrated in planning for all human services of that particular community.

I believe the five essential services as defined are too rigid and recommend that this specific requirement should be done away with in favor of a more flexible approach to the needed services needed in that area.

We should require, further, that a plan show how State and local services will be integrated, and how coordination of all services within an area will take place.

We must encourage development of integrated case management, so that the family rather than the individual becomes the focus.

Programs for geriatrics, alcoholism, drug user abuse, court-involved individuals, and children and adolescents should be part of the basic package of services.

Under this dynamic model of a package of services which can change to reflect new ideas, needs, the growth or diminishing of old problems, the Federal funding stimulus will yield results if applied to these areas:

1. Innovative methods of community-based care. When cutbacks go into effect, innovative programs of this type often feel the effects first.

2. Services for those in transition from State hospitals or other forms of institutional care—courts, detention programs, shelters, prisons—such as rehabilitation, half-way houses, home care, community residences.

3. There is a need for social skills training for those long institutionalized who need to know how to relate to the outside world.

4. Services integrated with general medical, social and other human services. This would help with achieving integrated case management and with seeing the person in the context of family and community.

5. Expanded mental health information services. Local offices should be opened or expanded, as the system of care can rarely be better than the information which rationalizes its creation and growth.

Evaluation is also essential. We need this to assess effectiveness, and to update services in relation to needs.

6. Innovative centrally run programs. Mental health services available for employees, prison mental health, citywide education, for the public, continuing education for mental health professionals, and research programs should be developed. Retarded, recovered and other handicapped persons should be employed by government as well as business and local agencies. Consultation with police, probation, social services day care, schools and other agencies should take place.

7. Flexible locational capabilities in order to provide funds for renovating and rehabilitating suitable existing structures the arrangement of which can be changed to fit changed needs.

8. Training and manpower. New types of services demand new training and new kinds of manpower, both professional and paraprofessionals—in short, true new careers. For professionals, training should be community- as well as medical-school based. Professionals need new training in new settings to provide new types of services.

I would then say that if we can take this kind of approach together we can begin to move on to adapting some of the innovative ideas or program services into a system which will be more responsive to human needs.

Thank you.

[Testimony resumes on p. 136.]

[Dr. Christmas' prepared statement follows:

STATEMENT OF JUNE JACKSON CHRISTMAS, M.D., COMMISSIONER OF MENTAL HEALTH AND MENTAL RETARDATION SERVICES, NEW YORK CITY

"EFFECTIVENESS OF COMMUNITY MENTAL HEALTH CENTERS IN NEW YORK CITY: MODELS FOR FUTURE DEVELOPMENT OF SERVICE"

I. Opening remarks: Overview of Federal, State, and city relationships

I wish to thank you for the opportunity to testify before you today on the experiences which New York City has had with Community Mental Health Centers, and to share with you the new thoughts and models which our experience has generated.

First, I would like to comment on recent legislative and administrative developments in Washington which affect mental health services. In the next sections, I will outline our experience with Community Mental Health Centers and indicate what we would see as vital future development of services with comprehensiveness and continuity.

Finally, I will briefly discuss State-city relationships and refer to the goals, objectives and changing concepts of the community mental health service which we hold in New York City and show how they relate to our proposals for new funding for community mental health services.

This has been a difficult period for mental health. Most mental health services were ultimately ruled in eligible for Title IV–A and Title XVI monies. Mental health patients have been inequitably treated in drafts of National Health Insurance legislation.

As the agency was initially organized, mental health was neither accorded a traditional full committee status in the New York City Comprehensive Health Planning Agency nor was the more advanced step taken to include a mental health viewpoint as integral to its constituents committees (an omission which recent collaboration has begun to undo). Visibility of mental health suffered a substantial setback in the reorganization which brought the National Institute of Mental Health into a relationship to the National Institute of Health which, along with budget cutbacks, will surely reduce the effectiveness of NIMH. Without special earmarked funds, benefits to mental health from revenue sharing will be minimal. Finally, the future of the Community Mental Health Center concept was endangered by Administration opposition to further funding. Continued professional training for psychiatrists through residencies and fellowships as well as for other mental health professional and paraprofessionals is even more tenuous since this was not included in the extension act which Congress recently passed.

II. Impact of community mental health centers legislation on mental health needs of New York City

Community Mental Health Centers utilizing Federal funding are operating in only six out of forty-nine catchment areas in New York City. Two other centers not receiving Federal funds follow the Federal guidelines.

The total budget for mental health, mental retardation and alcoholism services in New York City (exclusive of the State system) is $170 million. Total Federal input is $26 million, of which only $8 million is in Community Mental Health Centers. The bulk of Federal aid comes through Medicaid, and amounts to $18 million. Total Federal, State and City money in Community Mental Health Centers in 1972–73 is $20 million. Thus Public Law 88–164 today funds less than 50% of total CMHC funding, less than one-twentieth (1/20) of the overall city budget. Federal CMHC funding impacts on only six catchment areas out of fifty.

The Federal share of construction monies, where these were utilized, has always been small. For example, a recently approval construction application lists $2 million of Federal money for a $14 million construction project for a CMHC. The mental retardation provisions of Public Law 88–164 were never used; funding in retardation has come through other legislation pertaining to the disabled. Funding for alcoholism, which is administered by this Department, has come through Public Law 91–616, and amounts to $750,000 out of a city alcoholism budget which this year totals $10 million.

What has Federal money accomplished? Have we approached the goals of community involvement and participation in decision making, of comprehensiveness and continuity of care, of diminishing the role of the State hospital? Are services traditional or innovative? Have the principles of community mental health been extended along the public health model to a designated population? Have we moved appreciably toward meeting needs? The experiences in New York, while not typical, even of large cities, because of a relative abundance of services for some, illustrate a few of the results experienced nationwide in urban areas.

Certainly there have been successes. Two CMHC's located in the Borough of the Bronx have made it possible to offer services to a deprived population with high indices of need in all areas, a population that virtually lacked locally based mental health services prior to CMHC's.

One of these has worked cooperatively with the State Hospital toward an integrated approach to care. On Staten Island, the Borough of Richmond, a CMHC is making possible in-patient care on the island for the first time and will develop links with local ambulatory care programs. In the Borough of Brooklyn, a CMHC has been a national model for community involvement.

New concepts have been introduced through CMHC legislation requiring community involvement and consultation and education. They have been developed extensively in innovative programs. Even in more traditional centers, initial hesitant steps toward community involvement and community advisory boards and consultation, outreach, and education services—both new to mental health—have now been accepted as almost usual rather than exceptional, not only in FMHC's, but in other programs as well. True, the role of the community remains to be defined; the partnership is still an unsteady one, but the advances have been made in the direction of greater accountability and greater responsiveness.

But, too often, consumer and citizen involvement has been perfunctory tokenism. Few programs go beyond the advisory board model to sponsorship by community corporations, by councils of community-based programs linking networks of service, accountable to and controlled by the local community. We have yet to grapple with the issue of arousing and maintaining interest of consumers, many of whom are struggling for economic necessities, in what has been for too long a field they sought only when seriously troubled, whose relevance to the social factors in their lives was often neither apparent nor real.

On the negative side, further, a too narrow insistence on a medical model which insufficiently involved other human services and focused too intensively on treatment to the exclusion of rehabilitation and prevention led to a persistence of traditional approaches in far too many instances. Thus, people were excluded in CMHC's as they had been in psychiatric services in the past—because they were poor, or of racial minorities, or alcoholics or addicts, or children, or chronically ill.

Federal and State regulations combined stress the role of the general hospital, and the large teaching hospitals, with their municipal or voluntary affiliates, have grown in power and clout.

The prevalent interpretation of the concept of the community mental health center—as exemplified in the rush to buildings and plans and mini-Departments of Psychiatry—must be open to question. Somewhere in the past as we all joined the bandwagon, the idea of a comprehensive network of services—of all relevant human services within a defined area—was put aside in favor of the massive applications wending their way to Washington for the far-off program. Now we find ourselves bound to buildings designed to house large numbers of in-patients when the needs of today indicate far more ambulatory care; we are locked into structures which limit our ability to respond to changing program needs.

There has been little innovation in the content of services nor have linkages been developed. The five essential services are the traditional ones.

Education, health, the law, the world of work, were systems unrelated to the mental health non-system.

In the worst cases, services offered have often borne only a tangential relationship to the needs of an area. In New York City, for example, only three of the six Federally funded centers are located in neighborhoods which rank among the top 20 poverty areas (areas which, almost by definition, lack services). With little overall planning and technical assistance from City and State formerly available, well-established institutions were able to develop applications and have them approved. We must turn this around so that we fulfill our responsibilities.

Evaluation, when carried out, has been limited. Criteria have been related primarily to reductions in numbers of admissions and lengths of stay in State hospitals.

The Federal regulations specify a catchment area of 200,000. In New York City this means that expensive services would have to be duplicated for a small population and that differences in population required by differing service needs require waivers. There is a lack of funds for planning, information gathering and monitoring, as well as technical assistance. Problems in implementation arise at every interface between governmental jurisdictions, and between agencies

unaccustomed to a city department formerly more concerned with being a conduit of reimbursements than a program planner. Alcoholism, drug addiction and mental retardation have been afterthoughts and children have been neglected, a situation made more confusing by inadequate special grants. Yet the spirit of community mental health may persist and be successful.

III. View and recommendations on future community mental health services legislation

Here, I am confining my remarks to the needs of a densely populated urban area. Indeed, one aspect of the original legislation which may be subject to refinement is that of offering one model for rural areas, urbanizing intermediate-sized areas, and for the highly urban areas. At least three approaches should be spelled out in new legislation, for the three types of areas described.

The prevalent interpretation of the concept of the Community Mental Health Center today is a narrow one. A static physical plant is envisioned, rather than a dynamic network of services that would be comprehensive. Because the medical model of sickness was used, skills of other disciplines and capabilities of related kinds of service providers were not utilized.

Today we are looking towards a network of services planned for each community within the City which can be altered as new needs arise, or old ones attain or lose priority.

Thus, the goals of continuity, comprehensiveness and community involvement are excellent ones. However, the funding patterns and the forms and content of services should be made more flexible, and new priorities funded, to achieve these goals.

Specific recommendations are—A. *Over-all Planning Structure.*—1. Require a statement of community needs, and gaps of services, as a plan of how the local area would meet these needs. This could be revised annually, to allow it to remain up-to-date; priorities could be kept current.

2. Eliminate the specific five essential services.

3. Require that a plan show how State and local services will be integrated, and how coordination of all services within an area will take place.

4. Encourage development of integrated case management, so that the family rather than the individual becomes the focus.

5. Planning for geriatrics, alcoholism, drug users, court-involved individuals and children and adolescents should be part of the basic *package of services.*

Services—B. *What to fund.*—Under this dynamic model of a package of services which can change to reflect new ideas, needs, the growth or diminishing of old problems, the Federal funding stimulus will yield results if applied to these areas:

1. Innovative methods of community-based care. When cutbacks go into effect, innovative programs of this type often feel the effects first.

2. Services for those in transition from State hospitals or other forms of institutional care—courts, prisons—such as rehabilitation, half-way houses, home care.

3. Social skills training for those long institutionalized who need to know how to relate to the outside world.

4. Services integrated with general medical, social and other human services. This would help with achieving integrated case management and with seeing the person in the context of family and community.

5. Expanded mental health information services. Local offices should be opened or expanded, as the system of care can rarely be better than the information which rationalizes its creation and growth. Evaluative data is also essential. This provision would greatly contribute to continuity of care.

6. Innovative centrally run programs. Mental health services available for employees, prison mental health, city-wide education, for the public, continuing education for mental health professionals, and research programs. Consultation with police.

7. Flexible locational capabilities. Provide funds for renovating and rehabilitating suitable existing structures, the arrangement of which can be changed to fit changed needs.

8. Training and manpower. New types of services demand new training and new kinds of manpower, both professional and paraprofessional. For professionals, training should be community as well as medical-school-based. Professionals need new training in new settings to provide new types of services.

IV. Federal funding structure

Since, as was pointed out before, mental health services in municipalities do not stand to benefit significantly from revenue sharing, National Health Insurance or Titles IV–A and XVI, New Federal money—allocated to impact on all designated catchment areas, not just on a few—could be provided for dense urban areas as follows:

A. A city should be funded, according to a needs analysis and plan, with an amount of money that can be awarded to its sections and communities for:

1. Meeting gaps in priorities revealed by an ongoing community planning process—special target groups, elderly, alcoholics, etc.
2. Giving communities staff capacity to coordinate existing services and monitor changing needs (community based information system) for both planning and continuity of care.
3. Applying or developing innovative treatment methods.

B. Grants for citywide programs

1. Services accessible to employees. An occupation mental health model, on-the-job mental health treatment and prevention programs. Cooperation with unions.
2. Public education about mental health and mental retardation problems and services.
3. Applied research projects to test effectiveness of combined services or services for special populations.
4. Evaluation.
5. Data gathering, case registry, other aspects of information systems.

C. Community and citywide plans

1. Needs analysis.
2. Goals and Priorities statements.
3. Gaps in service and plans to fill these.

D. Create a system for information dispersal

1. Federal should gather evaluation results, innovative programs, education concepts, etc.
2. Disperse good ideas to all the cities; spin off operations results. The link should be at the National Institute level, tying research, demonstration grant and operations evaluation information together.

V. Issues, Barriers, and New Directions in Mental Health in New York City

New York City has been moving ahead to begin to develop the planning infrastructure which will make the administration of the proposals indicated above possible. I believe it would be instructive to those considering new legislation to hear of our problems and accomplishments.

New York State and New York City are working together to bring more services to communities and to reduce the emphasis on the traditional long-term, custodial State hospital or school. Unified Services legislation, signed by the Governor only this week to be effective in 1974, will for the first time encourage State and City to work together to develop a plan for integrated services with funding shared in such a way that the patients' needs, not the source of funds, will determine the service he receives. It is worth noting that the term Unified Services as used in New York refers to a more limited concept than is the case in California, where the term originated. Here, the State hospital system, is *not* being phased out, and separate budgets will still exist for City and State services.

The past years have seen a change in the organization of the New York City Department of Mental Health and Mental Retardation Service toward decentralization in Regional Offices; the construction, opening, and operation of six community mental health centers; the development of Borough Federations of City, State, public and voluntary agencies, citizens and consumers as the base for local planning; the development and funding of many new programs and networks of programs; and the linkage of State institutions, voluntary agencies and their resources as a part of network of Unified Services toward which we work.

Nevertheless "* * * in view of the current knowledge about the magnitude of mental health problems in this city, the existing inadequacies and fragmentation of many ongoing services, the obsolescence and ill-distribution of many facilities and the availability of new approaches awaiting implementation in mental health as well as in other areas of human services * * * to plan forward into the future is necessary."

Strengthened by staff and local planning groups in each borough, we seek to work collaboratively with others in meeting our goals for improved services in this City.

These goals are: First, to develop a system of care in which all services—public or voluntary, preventive, treatment or rehabilitative; city and state—are integrated to provide a coordinated and comprehensive system, to which each level of government contributes according to its abilities;

Second, to provide this care on a regional basis to a defined population so that services are accessible and available to those who need them and responsive to local community needs;

Third, to give priority to services for populations at high risk:

Fourth, within the limits of available resources, to provide services that are sufficient in quantity and high in quality;

Fifth, to monitor services and programs sufficiently well to ascertain their effectiveness, their costs, and their replicability, as well as to determine the need for new programs.

As the agency mandated by City Charter to supervise, review, plan and monitor community mental health, mental retardation and alcoholism services within this city, regardless of funding, the Department has a number of interrelated activities it must carry out to fulfill its responsibilities. They can be categorized as the planning and allocation of resources; implementation of plans; and monitoring, supervising and evaluating efficiency, equity, and effectiveness. Any consideration of future community mental health services should take these areas into account.

Consistent with the intent of Unified Services the City is already administering a joint city-state public-voluntary planning process which will result in the development and submission of a single comprehensive plan of service to the State Department. The established vehicle for such planning in New York City is the Borough Federation of providers and consumers. Subregional planning groups meet regularly, identify gaps and duplications, propose plans, state priorities for their locality and are advisory to the Department Regional Directors and their staffs. Boroughwide committees review issues of borough concern; state and local planning committees complement the local group activities.

The subregional groups include providers (both city and state, contract and non-contract agencies) and also related human services agencies (schools, courts health care, social service and other organizations), and citizens, both individuals and representatives of community and consumer groups.

In support of the principles of Unified Services, we established the policy of working closely with other public agencies, together developing programs and/or networks of service. We recommend that both Federally and locally such joint programming and creative funding that breaks down barriers to service be facilitated, and that restrictions that would make this difficult be eliminated.

The need to replace competition and jurisdictional rivalries with cooperation goes hand in hand with the need to face several other issues which, if not dealt with, may hamper progress. We are painfully aware that mental health is part of a non-system; fragmentation, lack of coordination, many gaps and some duplications, are the rule rather than the exception. Fiscal constraints, limited definitions of programs; rigid adherence to guidelines appropriate for one type of community and not another, and models of care that fail to take account of changing times and conditions—all these work against improvement of service systems.

Equally as important is the need to develop an approach to service which is based upon concepts appropriate to those who are the focus of service—the people, not the institution. It is these principles and premises which guide the Department in its work and which we believe are worthy of consideration.

A basic premise of community mental health is that responsibility should be assumed for the health needs of a defined population. Attention is given not only to current cases and current needs, but there is also concern with potential cases through efforts at primary prevention. This responsibility include provision of a full range of coordinated services in quantities sufficient to meet the mental hygiene needs of all persons in this designated population, regardless of whether or not they have been labelled patients by themselves or by others. In large cities the catchment or service area concept, as developed, has only fortuitously matched the boundaries of existing neighborhoods, even though the aims of the provision of services on a regional basis are not only to ensure that they are both available and accessible, but are also responsive to locally identified

needs and expressed demands. Ideaiiy, programs draw upon the cuiture and iife style of the community and reiate to its peopie, not oniy as recipients of service or as iow paid staff but aiso as co-pianners and as primary therapeutic agents, both professionai and paraprofessionai.

Further, there is emphasis on new modes of service organization. This innovation is particulariy marked in programs serving persons at high risk, inciuding those of iower socio-economic and/or raciai minority status who have not previousiy been served in large numbers by the private practice of psychiatry, in moderate fee psychotherapy ciiuics, or even in pubiic mental hygiene ciinics. Muitiple forms of interventions are deveioped, ranging from the medical, psychiatric, and somato-chemicai to sociai, educationai and environmental approaches. A continuum of care; varied types and sites of service; organizationai structures providing degrees of support-independence; and a variety of residential arrangements are encouraged. Immediate avaiiability; problem-centered responses; famiiy, miiieu and group therapies; and short-term interventions are characteristic of this approach. This is a far cry from a rigid adherence to five essential services.

Yet, in keeping with an emphisis on decentraiization, there is acknowledgement that locaiities and people vary; so their needs also must vary. It thus becomes necessary to describe the conditions and assess the status of the specific population under consideratiou and to use these data for rational planning. The epidemiologicni approach and the collection of information can reveai patterns of utiiization and gaps (and occasionaiiy, dupiications) in service. Demographic data and the development of sociai indicators may suggest possible interreiationship of social-economic factors and mentai disorder. They also raise questions regarding influences tending toward or deterrents hindering entrance into the health care systems. Such utilization and information will have to be sought increasingiy if primary prevention is to be carried out more extensiveiy.

Mental health services are conceived to differ both quaiitatively and quantitativeiy. Indeed, direct service (including psychotherapy and casework) should now be only one of a variety of therapeutic, social and psycho-educational activtities. Consuitation and education have assumed a major place beside group aud individual psychotherapy. Day treatment programs, diagnostic and training services for the retarded, remediation, therapeutic residencies and group homes, sheidered workshops for the mentally handicapped, rehabilitation programs and activities therapies must be, if uot yet the rule, certainly uo ionger oniy the exceptiou.

In this view, mental health is conceived as optimai pyschosociai functioning. Mental disorder and social dysfunction are considered as disturbances on intrapsychic, interpersonai and sociai leveis, resulting in a variety of outcomes, including aitered communication, loss of adaptive ability, and psycho-pathological symptoms. Community mental health services must take ali these factors into account.

Ideaiiy, community mentai heaith programs should be capable of providing for the individual or family services which are available, accessible, related to his life-style, and effective. Members of a community should be invoived from at least three points of view: as consumers of services, as participants in planning, advice, control and in decision making; and in roies as staff providing services.

This requires a greater openness to evaiuation and monitoring than we as psychiatrists have shown; far too many of hypotheses have gone untested. It would be unfortunate to discard ali of traditionai psychiatric services as too costiy, time consuming and eiitist. It would be aimost equaiiy as unfortunate to assume that commuuity mental heaith or sociopsychiatric approaches, which have to date, stood the test of neither time or evaluation, are by their very nature, effective. Program planners and poiicy makers should both be concerned with evaluative criteria, in spite of the fact that hard data are difficult to come by. It also requires coiiaboration in which professional, paraprofessionai and community viewpoints are vaiued. The need for evaluation is most marked in relation to preventiou, particuiariy among children.

The idea that there should be concern with efforts to maintain the heaith of the well exerts iittie pressure on legisiators who doie our reiativeiy few funds for health care, iii men are a relatively powerless constituency. Well men (and health professionais) have not yet learned that health maintenance is a goal to be attained.

The resuit of preventiou are difficuit to measure, particuiariy in areas of psycho-sociai disorder. Yet, we must compiement our iong-standing commitment to treatment with energies and resources devoted to prevention and rehabiiita-

tion. Difficult as it may be to measure the effectiveness of preventive programs or of consultation to social agencies, the clergy, the police or schools, nevertheless, our services may be multiplied as we reach the helpers and caregivers. It is in the social system of the school that much of the child's world is centered; it is to the natural support systems of his community that the individual turns, before he enters the system which we define as the field of mental hygiene. It is this same community—but not of the addict, the alcoholic that the chronically mentally ill, often does little more than exist, for lack of rehabilitative services. And it is the same community that has tracked the child in trouble out of the mental health and educational system and into the courts, the detention centers, the training schools and prisons.

This implies the need for services which recognize the social context, and without forsaking that which is distinctly psycho-therapeutic for sociological intervention, encompass the immediate and pressing concerns of the individual in his familial and social environment. It means the provision of service where the people are, through a variety of approaches, and the use of new patterns of staffing. It is not only the SRO's or the detention centers or the schools, but the street corner society, the well-baby clinic, the Vietnam veterans in the unemployment office, the retarded adult hidden away in his family. If I dwell at length on the need to reach the socially disadvantaged or those-like the retarded-considered expendable, it is only because the inadequacy of services and the maldistribution of programs are so marked for those whose lives are scarred by poverty, war, racism, and a devalued social position.

It is with all our citizens that we must be citizens, that we must be concerned as we work together to extend and improve mental health and mental retardation services. The opportunity that we take today to consider our tasks for the future may, hopefully move us beyond the limitations of the past.

Mr. SYMINGTON. Commissioner, I want to thank you for an excellent, succinct statement and assure you that your full report will be made a part of the record.

I have one or two questions at this time. We may have others to submit in writing.

There has been some criticism in the Congress of the suggestion that the community mental health centers be required to assist in the field of alcoholism, drug abuse, and so on and to mix the people up in some fashion where the service renders each patient less than he ought to get from the service in some way, it hurts. How would you respond to that, Dr. Christmas?

Dr. CHRISTMAS. I would disagree quite heartily with that. I think that approach would tend toward an elitist situation which means the mental health approach is at the highest level but the addict is at the bottom of the scale.

If we talk about mental health and retardation, we have to consider the range of disabilities of which alcoholism and drug abuse are unfortunately a part. If we look at the people coming into public institutions in New York, 30 to 40 percent of the people enter with secondary or primary diagnoses of alcoholism.

We are avoiding dealing with a specific problem to which our mental health energies ought to be directed. Certainly we need both specialists within centers and we need specialized programs staffed by persons with particular skills in dealing with particular kinds of problems and limited to certain populations. Yet, equally as important we need also specialized programs within those multipurpose centers; they too should be available. Further, we need to stop discriminating against and excluding from our programs alcoholic or addicted persons.

Mr. SYMINGTON. Thank you. Mr. Hastings?

Mr. HASTINGS. Thank you very much, Dr. Christmas. Your statement was, in my judgment, one of the best I have heard on the sub-

ject. I suppose one of the reasons I say that is that I had my staff people suggest some questions and you answered all their questions in your statement.

There are a couple of areas I would like to briefly touch on. Are provisions actually being made for the termination of Federal assistance in the program today? Are provisions being made for States and localities to be able to carry on totally after the Federal assistance terminates on schedule?

Dr. CHRISTMAS. In New York City, we have been for the last year trying to update what was a master plan of 1967, to see what services should be developed within the city. I joined the Department about a year ago, at that time we were taking a long hard look at where services should be going so I can say that, although we knew perhaps that cutbacks would be coming at some time and they are going to be a great disadvantage, yet New York, and perhaps other large cities, have been able to look at their total program needs and to plan for them.

It does not mean we are going to have the revenue to do it but it does mean we have begun to look. Even the termination in itself was for some people within the sphere of something that was going to come. Yet, 7 or 8 years seem far enough when one begins to plan.

Mr. HASTINGS. That is a concern we quite often express because too often when any seed money goes into a program, the effort is always made for the Federal Government to continue on a permanent, ongoing basis. That was not intended and many consumers, I suspect, feel that the Federal share will always be there.

It was never intended to be permanent, as we both know. We do have a concern that the communities themselves start to prepare themselves to take over the full scope of the program after termination.

Do you have any relationship with comprehensive health planning in the city of New York?

Dr. CHRISTMAS. Yes, we do. In New York City, our planning groups are interrelated to CHPA and in local communities, we have local, city and State and voluntary agencies working together in our subregional planning groups. On the executive board of each borough there is a representative from CHPA.

A number of our staff, including myself, serve on the Comprehensive Health Planning Agency committees. When CHPA started in New York mental health was not one of its standing committees. We are now considering that perhaps we should integrate the awareness of mental disabilities and competence in this area into all communities.

Mr. HASTINGS. There is some feeling among the gentlemen on the committee that, as we write the long-range programs that we are discussing, we include mental health, comprehensive planning on a regional basis, Hill-Burton, and perhaps some others, in a consolidated approach to provide better health care to the country.

How far we should go along this line I am not sure at this moment, but the general thrust of the legislative intent right now is to do that. So I am delighted to hear you have that relation with CHP.

I have many, many questions and I will say to you as I did to Dr. Miller that I hope we have an opportunity to discuss this most important and serious matter at a later date.

Dr. CHRISTMAS. We will be ready.

Mr. HASTINGS. Thank you very much.

Mr. SYMINGTON. Thank you very much.

As so often happens when we go out in the field, it happens that we hear the expert testimony from the professionals and fail to hear from the community folks, and I want to be sure that we don't make that error today.

So, I shall call now on Mr. Edwin J. Cooper of the Maimonides Community Mental Health Center. I think there is another community group—Mrs. Sabino. Perhaps the two of you could sit together at the table.

STATEMENT OF EDWIN J. COOPER, CHAIRMAN, COMMITTEE TO PRESERVE COMMUNITY MENTAL HEALTH AND RETARDATION CENTERS, BORO PARK AND SUNSET PARK, BROOKLYN, N.Y.

Mr. COOPER. Congressmen Hastings and Symington, and distinguished guests and community people, I am the chairman of the committee to preserve community mental health and retardation centers in the area of Boro Park and Sunset Park community of Brooklyn.

Before the Community Mental Health Center Act was put into effect in 1963, people were being put into State hospitals and State schools and were being treated like dogs. I know this from experience, not from talk or from reading about it. Since the foresight of our late President Kennedy, the Community Mental Health Center Act was put into effect in 1963.

Due to the fact that we did not have any mental health centers, when I had a nervous breakdown, I was committed to Letchworth Village in New York State for 13 years, and I hated every moment of it, because I didn't like the way I, as well as other patients were treated. When I was discharged from Letchworth, I made a vow I would do everything in my power to see that this does not happen to other people.

The situation has not subsided, but due to the fact that we have Maimonides Community Mental Health Center in the Boro Park and Sunset Park area of Brooklyn, the commitment to State hospitals has dropped by 70 percent, from 200 to 50.

This decline is due to the fact that inpatient-outpatient services, and treatment and prevention programs are right in the community. We residents of Boro Park and Sunset Park urge Congress to extend the Community Mental Health Center Act and allow us more funds to expand our wonderful program more.

In April 1973, there were nearly 2,000 enrolled patients being treated at Maimonides Community Mental Health Center. Over the past year about 4,900 different patients had received direct clinical service at our center.

Each of our two neighborhood service centers averages about 1,000 contacts per month with community residents. The Community Coalition alone served over 4,700 individuals through its 13 service programs. A total of 20,000 individuals receive a variety of services from all the programs of the center.

President Nixon has said if he extends the Community Mental Health Center Act, he would have to raise taxes. I don't think so. If he would force the rich corporations to pay more taxes, he would have enough money to give us and even expand the Community Mental

Health Center Act. The rich corporations and the big real estate companies pay less taxes than middle- and low-income people.

If we allow President Nixon to get away with this, the commitment to State hospitals will increase and costs of custodial care will rise.

Several years ago, due to my volunteer work at Maimonides, I was able to help a family with a 4½-year-old retarded daughter. This retarded girl is also hard of hearing. The doctor said she could be helped by attending a school for hard of hearing.

The mother went to the Department of Social Services to ask for financial help. The official and Commissioner Sugarman stated that the child could not be helped and should be placed in an institution.

I fought this decision and got approval from the State Department of Social Services for the city to pay transportation costs for the child. If you could see the child now, you would not believe that she is the same person, because her hearing has improved and her mental capacity has also improved.

Therefore you can see that it has been proven that the retarded person can work and earn a living so he will not be a tax burden to the government. We should not only insist that President Nixon sign the Kennedy-Hastings bill (S. 1136) into law, which extends the Community Mental Health Center Act for another year, but we must put pressure on Congress to give us another Community Mental Health Center Act next year with more funds so we can extend our mental health programs by having more community mental health centers and by opening more workshops in the community which will teach the retarded how to work and live in the community and be useful citizens.

We can also use more funds to open halfway houses where patients from State schools and State hospitals can be put, and go to sheltered workshops. This can be done without raising taxes, if Congress puts a stop to President Nixon's wasting money on defense. It is a proven fact that most of the tax dollars collected each year go for defense.

In the area served by Maimonides Community Mental Health Center, we have a community organization called Community Coalition, Inc., which services the people of Boro Park and Sunset Park. The center's administration, the "Fight Back" Committee, the Community Coalition and other groups urge Congress and President Nixon to give us more Federal funds so we can give more services to people in the community.

I have with me several statements from other community organizations, schools, etc., who support us wholeheartedly and who want to have their statements inserted in the record.

In closing, I urge every consumer and community group that will hear of this through radio and television and by newspapers to write and send telegrams to President Nixon and your Congressman to continue the Community Mental Health Center Act—united we stand; divided we fall.

Thank you.

Mr. SYMINGTON. I want to thank you very much, Mr. Cooper, for that very fine, definitive, and illuminating statement.

We will welcome any additional material which you would like to submit in the next few days from friends or likeminded workers in the vineyards there.

Thank you so much for that fine statement.

[The following letters were received for the record:]

PUBLIC SCHOOL 230, BROOKLYN, N.Y.,
June 11, 1973.

DEAR MR. COOPER: As the resource teacher for a unit of abont eighty retarded children, the news that funds may be curtailed or cut off for the Maimonides Mental Health Center comes as a terribie blow. Many of onr children depend upon the center for Saturday play groups, for summer day camp programs, for diagnostic evaluations. Their parents need help in understanding the problems of raising a child who is retarded. They need a place to share ideas with parents who have similar problems. This is given them as the Malmonides Mental Health Center.

Too often our children wiien home from school, sit in front of television. There are not enough recreational alternatives now and the chance that programs, which help our children learn social skills, may also be done away with is, in my opinion, criminal. Instead of curtailment, more funds are needed to expand the Mental Health Center so that our children can become better equipped to grow into independent, useful citizens.

Please feel free to call on me for any help to win this battie.

Fraternaliy yonrs,

MRS. ROSLYN ROSIN,
CRMD Resource Teacher.

BORO PARK FRIENDSHIP CLUBS,
Brooklyn, N.Y., June 14, 1973.

HONORABLE CONGRESSMAN: 4324 Eighth Avenue is a storefront in Brooklyn. It is the meeting place of a group of senior citizens who are members of the Friendship Clubs connected with Maimonides Community Mental Health Center. It is being brought to the forefront because of its unusual purpose.

There are many senior citizen groups throughout the city. These men and women in retirement find opportunities to socialize and fraternize. Their activities provide them with stimulation and shared interests with members in their community.

Age does not discriminate. In living, it reaches the rich as well as the poor; the sick as well as the healthy; the intellectual as well as the average. So the blind also become old.

When one is blind and old, the days of one's life can be very lonely and sad.

And now we come back to that storefront on 8th Avenue, in Brooklyn. There on Wednesday mornings, the very good, kind, friendly members of the Friendship Clubs meet with V.C.B. Community Services, and involve themselves with a group of about 18 blind men and women. They take us to and from; they take us shopping; they help repair clothing, using a sewing machine which average blind people cannot do. They sew on buttons which is especially helpful to the blind men in the group. They plan day outings where we are included; they have parties; they arrange for interesting speakers to come down to the meetings.

These are splendid people, rendering a wonderful service to a group of blind people. They are unusual in that they feel they are not doing enough. They say they enjoy being with the blind group as much as they are enjoyed by the group, perhaps even more.

I am one of the blind women enjoying the activities of these fine people. I wish I could reaiiy tell you what it means to get out, even once a week, to have people to talk with, to be helped in areas we need help, to feel integrated with people. Blind people iive in darkness, they cannot enjoy someone's smile, so a word in greeting is as a smile to the sighted. Since everyone knows how they react to a smiie, the significance of a word to a blind person can be appreciated. Most blind people do not want much, just to be accepted as people, just to receive a smiie, to them a word.

Sincereiy,

JOAN FOX,
Club for the Blind.

BORO PARK FRIENDSHIP CLUBS,
Brooklyn, N.Y., June 14, 1973.

HONORABLE CONGRESSMAN: What has the Boro Park Friendship Club done for me? If I didn't have a calendar I wouldn't remember my age, as the club has given me young thinking. With all the activities such as dancing, crocheting, lectures, trips, also the courses in art, current events, gardening in containers I have been in these past three years I feel alive and can forget my ailments, and that I am a widow.

I look forward to seeing my friends at meetings. They seem to care if one is away and call us and send cards when we are sick or have birthdays. We feel wanted and important.

This center must be kept open for us or we'll be lonely and sick.

Sincerely,

ANNIE JACKSON.

BORO PARK FRIENDSHIP CLUBS,
Brooklyn, N.Y., June 14, 1973.

HONORABLE CONGRESSMAN: I would like to tell you what the Mental Health people have done for me through our Senior Citizens Club.

I retired as a licensed practical nurse after 28 years of service in Kings County Hospital. I was home one week and was ready to climb the walls when a friend asked me to visit the Friendship Club. I enjoyed it so much that I joined right away.

I have been in the club almost from its beginning five years ago, as program chairlady, vice president and then president. I am now past president and still enjoying our club. Attending our meetings, classes, parties and everything possible has saved my life as I surely would need a psychiatrist if I could not always have a group of friends to replace those who are gone.

If, God forbid, this building has to close its programs for people who live in the community and are not "patients" what will happen to the 1,300 people in the four clubs sponsored by the Mental Health Center?

Sincerely,

ANNA SHAW.

BORO PARK FRIENDSHIP CLUBS,
Brooklyn, N.Y., June 14, 1973.

HONORABLE CONGRESSMAN: Because we hear that the Friendship Clubs are in danger of closing we must tell you what pleasure we have gotten from the club these past 3½ years.

Now that we have moved to Florida we hope to find a club down here so we can be of help to others and be helped as the Friendship Club at Maimonides has been to us.

I pray that the Mental Health Center will get the funds that we make sure the clubs can go on.

Sincerely,

GLADYS MCGLYNN.

Mr. SYMINGTON. I would, at this time, like to welcome Mrs. Sabino to the stand. She is representing the community coalition.

STATEMENT OF MADALENE SABINO, CHAIRMAN, COMMUNITY COALITION, INC., BROOKLYN, N.Y.

Miss SABINO. I, Madalene Sabino, chairman of the Community Coalition, Inc., of the Boro Park and Sunset Park area of Brooklyn, N.Y., will testify on behalf of the community coalition, at this congressional hearing, on this Friday, June 15, 1973, re: "Congressional Oversight on Community Mental Health Services".

In accordance, I respectfully wish to address myself to the chairman, the Honorable James Symington of Missouri, the Honorable James Hastings of New York, the distinguished members of the panel, and guest assembled here.

The traditional patterns of delivery of mental health service prior to the inception of the 1963 Comprehensive Community Mental Health Centers Act can only be presently compared to the findings at Willowbrook, and its related shame. The antiquated concept of custodial institutions was the primary source for Mental Health and Mental Retardation Services before the 1963 act was passed.

The changes from the traditional delivery of services in mental health in those institutions of old has come from the pressure applied by the people on our governmental, health, education, welfare, economic, and political institutions.

The pressure of the people and the research conducted by the varied related technologies: pointed its finger directly at the enormous incidence and prevalence of mental illness and lack of mental health in urban areas, as well as the significant relationship between social conditions, social stress and the incidence, prevalence, and severity of mental illness in urban populations.

The researchers developed new modalities of treatment, new techniques, and a broader concept of the scope of mental health and mental retardation which made obsolete the prison-like medieval criminal approach towards the people that suffered from a lack of mental health.

The brilliant identification, determination, and legislation of that Congress of 1963 revolutionized the field of mental health through the Comprehensive Community Mental Health Center Act.

The intent of the Community Mental Health Center Act was to develop over 1,000 community mental health centers across the Nation. These centers would differ from the traditional facilities in that the CMHC facility would be responsive to the mental health needs of all the residents in a given contracted geographic area. This would be carried out through the officially mandated provision of five basic elements of services by all Community Mental Health Centers which are as follows:

1. In-patient services.
2. Partial hospitalization (day and night).
3. 24-hour emergency services (7 days a week).
4. Outpatient services.
5. Consultation and education services.

Through the multidisciplinary approach of community mental health centers where all services would stress continuity of care for patients, while unifying the processes of intake, diagnosis, and treatment. In addition to the community mental health centers being housed in the community so that patients would not be sent away from their neighborhoods for treatments, the symbol of progress in the mental health field was achieved.

Such a symbol of progress exists in our community, such a symbol of progress should exist in every community according to the original intent of the act.

Putting the act in perspective, we are only one-third of the way from completion of the original mandate. The community mental health center program has been acclaimed as one of success, and now, the

highest executive office in the land contemplates the termination of a successful program before reaching the peak of success contrary to the obvious principles of good logic.

In our area, Boro Park and Sunset Park, in Brooklyn's Community Planning District No. 12, we have a microcosmic sampling of the ethnic representation found in our Nation. We are proud to have one of the best examples of the intended aim of the Community Mental Health Center Act. Here diverse ethnic, socioeconomic, and religious groups have been assembling around mental health common issues and the promulgation of cultivated understanding amongst different people thanks to the Community Mental Health Center Act.

The services and programs provided by our mental health center reach a vast population. These services range from advice to intensive therapy or hospitalization.

The indigenous community has accepted the concept of local comprehensive community mental health services through the active involvement of local community organizations in the field of preventative mental health. These organizations have lifted the stigma attached to mental illness, made visible and acceptable the concept of comprehensive community mental health, and, have interacted with C.M.H.C., the community and other agencies to make possible the want for expansion of the services provided and presently in existence.

The interaction of the philosophy of the highly esteemed leaders of Maimonides Community Mental Health Center, namely, Dr. Montague Ullman and Dr. Mark Tarail, the intent of the Community Mental Health Act, along with the many responsible leaders of varied grassroots organizations—over 30 groups—in the area precipitated the chemistry which made possible the Community Coalition, Inc.

The community of Boro Park and Sunset Park supports and applauds the Hastings-Kennedy bill which extends the Mental Health Act for one more year. We wish to further testify on record that further legislation be enacted to continue the mandates of the Mental Health Act. We, the community feel that if the Mental Health Act is ended as proposed by the present administration—it will be like taking the floor from under the feet of the numerous people that are benefiting from the Mental Health Act and it will be like dropping the same floor on the potential benefactors of the mental health services.

We would also like to bring to your attention that the potential for mass and civil disobedience and disorders is increased in the same proportion to the loss of human services—especially in the conglomeration of people and problems in the urban centers of the land.

The investment manifested in the mental health services provided through the legislation at issue cannot be measured in dollars and cents—because it is an investment in the health of Americans.

We feel Thomas Jefferson would agree, "by the people, for the people", et cetera.

We also wish to testify that it is imperative that our center, the Maimondes Community Mental Health Center, be allowed to continue any loss of Federal Funds. As we all know, Maimonides Community Mental Health Center is renowned nationwide for the type of humane treatment that is given to the mentally ill plus recognition of its high-quality clinical services.

In the support and in the technical assistance provided by the Maimonides Community Mental Health Center to the Community Coalition, one can see the close working relationship of the center to the community.

By adding a few words regarding the background and history of the coalition you will get a clear picture of how important it is to this community that this community mental health center be allowed to continue intact:

PURPOSE OF THE COMMUNITY COALITION, INC.

The Community Coalition is an organization made up of 38 community groups which run the gamut of many different ethnic and socioeconomic background and whose common denominator is working together toward the betterment of their community.

One of our main goals is to promote mental health through love, work, and power. This power comes by the people defining alternatives to their own needs and most important seeing them realized.

It is also supportive of, and organized around, community issues and hopes to continue with as many groups as possible, that we can accomplish change while at the same time working toward a more integrated and understanding society.

BACKGROUND OF THE COMMUNITY COALITION, INC.

In the spring of 1970, 33 community organizations from the Boro Park/Sunset Park area came together at a very unique meeting. Its purpose was to diminish rivalry between community groups and instead form a united group of community people whose organizations would work cooperatively for the betterment of the community. These groups represented a cross section of almost all the ethnic groups found in our society, that is, Italian, Irish, Scandinavian-Norwegian, Spanish-speaking community, and Eastern European Jewish, including a substantial number of Hassidic Jews, including all economic strata.

Each one of these groups reported what they felt was a community problem area, day care, senior citizens, housing, welfare, lack of facilities for retarded children and adults, tutoring for the underachiever, lack of facilities for youth and related problems, et cetera.

Out of this meeting the Community Coalition was formed, a group dedicated to making this community a place to move into, rather than out of.

Armed with this firsthand knowledge of what was happening in our community, the coalition approached Maimonides Community Mental Health Center and strongly submitted two requests: (1) That the coalition be given funds to hire local community people to work in programs that we, the people defined, rather than have someone from outside the community tell us what our problems are, and, (2) that once these people were hired, they would be trained by the mental health center if their parent boards so request. These requests have since been granted.

The effects of the coalition have been very important. Since the coalition only hires community people, over 70 jobs and close to $500,000 have gone into the community by way of jobs created and

services given. In addition, and perhaps more important, community people have received training which will enable them to combat problems that affect each and every one of us.

At present the coalition through funds it receives through Maimonides Community Mental Health Center has set up programs—of some of its member groups—to deal with many of the community problems.

1. A day care center program, namely, St. Andrews Day Care Center which deals with preschoolers. St. Andrews has since become funded through the Department of Social Services.

2. Youth groups formed to deal with the problem of drug abuse, school dropouts, behaviorial problems and as a basis to establish peer group pressure as a preventative to many problems related to youth. These groups do have the backup support of the professionals in CMHC. These groups are essential to the community as there are a wealth of young people in the area and a dearth of recreational facilities or places for the young to go to. These groups are namely: Sunset Park Youth Association, Dahill Road Park, Begin-Together, Latin-Stars and Boro Park Youth League. At present, the Boro Park Youth League entered a proposal to the subregional CPD No. 12 Board for a multipurpose youth center in the area to service the youth in our area. This youth center wold be staffed by professionals and paraprofessionals, in order to approach the many and often times complex problems, that beset our youth, in a comprehensive manner.

We feel that by letting our youth feel wanted in our community, and being available when a helping hand is needed, that many serious problems are being prevented. At the present we are saddened by the rate of increase in the incidence of school dropouts, et cetera.

3. The community school program which is a program geared to the borderline retarded children who cannot be placed in any existing institutions, because of various reasons. It is heartening to note the progress that has been made with these children who were, "pushed out of school because there was no place for them."

4. The Laughing Tiger Day Camp program which deals with special children with special problems. These children have been referred to us by school guidance counselors, therapists at the center, et cetera. The camp is in operation on Saturdays and 5 days a week during the summer. Sad to state, there is a large waiting list of children referred to us that cannot be accommodated because of lack of funds.

5. The Young Children and Adult Retardate program which deals with the retarded child and adult through a lounge and socialization program. Sad to state this program has a real need which cannot be fulfilled because of lack of funds and resource, a workshop. This workshop would serve to give the retarded person his rightful place in society by allowing him to lead a more meaningful life.

6. Care With Ahava program which dealsw ith the underachiever through a tutoring program which raises the child self-esteem by giving him positive experiences. One aspect of the program is an informational and consultative aid service. Distrust of the "outside" world, and not knowing where or how to begin once the distrust is overcome has succeeded in isolating the Hassidic community even more than it should be. Door to door canvassing to counsel and provide information, and general rights advocation, welfare, medicaid, food stamps, et cetera, all fit into the Judaic concept of "self help" and therefore

somewhat more readily accepted when offered from "within" the community.

Sad to state, there are many children waiting to be serviced by this program.

7. Boro Park Welfare Rights Organizations and Sunset Park Welfare Rights which are two groups which deal mainly with welfare and low-income individuals and families. As we well know, the problems of the poor are many and complex and perpetrate much mental anguish. These groups help to alleviate mental distress through counseling, referrals to proper agencies, developing programs such as: High school equivalency programs, tutoring programs for the immigrant who has a language barrier, cultural exchange programs, et cetera. The emphasis on individual and group counseling is great as the incidence of suicide is high in these two particular areas, which are poverty pockets.

8. The Sunset Park and Boro Park Community Consumers Health Education Cooperative which is a program which deals with the nutrition of the very low-income families in the Sunset Park area. To understand the importance of this program in a mental health way, we must also be aware of the fact that the individuals and families this group deals with are mainly Spanish-speaking from a different environment and therefore the staples they are used to, in the environment they emigrated from, for a balanced diet are not the same. Along with the backup service of a professional nutritionist these individuals and families are taught how to use the staples in a nutritional way. This is very important, as it is a known fact that some types of mental deficiencies are due to a lack of protein, et cetera. These individuals and families are also referred to professionals in the mental health center.

9. Tutor therapy program which pays for two coordinators to train laymen and professionals in Dr. Pollack's Intersensory Reading Method. This scientific approach helps the underachiever through many positive experiences which aim to raise the underachiever's self-esteem and ego to the point that the child reaches the reading level of the class he attends and is able to "keep up." Regular scientific tests are given to these children and at times these tests indicate that there may be a more serious problem. These cases are referred to professionals at the developmental center which administers diagnostic testing, et cetera.

10. Central staff which act as liaison between the funded programs, named in Nos. 2 through 9, and helps to organize the community around mental health issues, acts as resource to community with respect to referrals, et cetera, also acts as resource to the mental health center on a "community level," research alternate means of funding.

In conclusion, the issue facing us today, the extension for 1 year of the Community Health Centers Act is an issue that will have a profound impact on the American public. At this point, we are at the crossroads of that impact: If the extension is passed, a positive chain-reaction will take place. On the other hand, if the extension is not passed, a disservice with its related negative impact will cause a negative chain reaction.

We have come a long way in the field of mental health in the last 10 years: From a caretaker approach of patients, to a model approach of

comprehensive services, a move away from specialized fields that would treat people as curions, interesting objects with one single problem, or one set of unrelated problems, that were dealt with in a fragmented approach by specialists.

The history behind the movement for "community mental health" is one that parallels that of the aeronautic successes of NASA: They are both results of R. & D. coupled with public demand. One benefits us directly, the other indirectly.

With the public support of space exploration a substantial number of successes have been achieved in the field of man in space. I am confident that with the public support of mental health legislation, we can achieve far-reaching successes in the field of man on Earth.

Public support and involvement has been one of the primary elements contribnting to the success of the CMHC program. Community initiated and developed programs in preventative mental health have acted as the light up front, illuminating the road and contributing to the success by removing the stigma and making visible and acceptable mental health services.

The community coalition has been recognized by the American Psychiatric Association through a significant achievement award. It is disheartening to see that in H.R. 7806 a discontinuation is proposed in the category that has fostered and made evident the existence of the community coalition. We urge Congress to legislate more funds to continue community organizations working in mental health such as the coalition, the important role of such organizations cannot be and should not be discontinued.

Let the record of these consumer operated, initiated, and developed grassroots organizations be the prolog for continued fruition.

The concept of consumer participation in all the facets of planning, development, and implementation of mental health services is being threatened by the proposed discontinuation of the consultation and education category in H.R. 7806. Consultation and education has been one of the five basic elements of service in the original Mental Health Act. Consultation and education has been the channel through which consumer participation has been fomented and expanded.

We urge the Congress to continue funds for the category of consultation and education.

[The following addendum was subsequently received for the record:]

ADDENDUM TO THE STATEMENT OF MADALENE SABINO, CHAIRMAN, COMMUNITY COALITION, INC., BROOKLYN, N.Y.

We wish to add that we have received resource information thru the Community Mental Health Centers News (see copy attached, for your convenience), dated June, 1973, that the Authorized Funding under S1136 and HR7806 show Cousultation & Education to be a separate category. Furthermore, that under S1136 there is 5 million dollars appropriated under this category and no monies under HR 7806.

We the commuulty take exception to the fact that C & E may in fact be segregated from the five basic mental health services mandated by the Commuuity Mental Health Services Act. May we with all due respect, bring to your attention that C & E monies have made it possible for organizations such as the Community Coalition, Inc. to function and in turn such organizations have not only helped to erase the stigma of mental health services given in a Mental Health Center but it also serves to bring the community together in a "therepeutic" way thru involvement and interaction of people committed to "mental health". The

Coalition thru the mental health workers it employs and thru the many volunteers (it trains) has helped in the following ways:

1. Referring clients to the professionals in the Center.

2. In a preventative way lightened the caseload of the professional, since the professionals and Mental Health Workers of Maimonides Mental Health Centers many times use the Coalition as resource.

3. By referrals to the proper city, state, federal agencies plus fraternal, etc. organizations in the community—we have helped thousands of people find an alternative to their problems and thus alleviate their mental distress. As we all know mental distress many times builds up thru frustration and bureaucracy which the average person does not know how to deal with.

4. Encouraging organizations to define their needs and develop and initiate services to meet with these problems.

5. Referral to various funded and non-funded organizations in the Community Coalition.

6. Teaching community residents to become actively involved in community boards (of all descriptions) and in both Maimonides C.M.H.C. and the hospital, in order to insure that the proper services are given. We also have many sophisticated citizens in the area who take the responsibility to see to it that our Mental Health Center and Hospital is run in an "honest" way. That is, the community holds the hospital administration accountable that they must open up records to show how the money is spent. Therefore, the word "honest" is being used only in a figurative connotation.

We would have to go on with pages and pages if we were to trace all the positive effects of the Community Coalition. The Community Coalition is good business in the sense of mental health and also in dollars and cents. Thru the preventional and rehabilitative (limited) aspects of our organization—it cannot be measured in dollars and cents how much money is being "saved" at present and in the future by helping a community thru love and work to help its future citizens to find their place in society.

Therefore, you must agree with us that it would be not only horrendous to do away with C & E but shortsighted in doing away with a commodity that is so valuable it has no value. With all due respect, we cannot allow the fact that (at present) third party payments cannot be paid to C & E. C & E must not be jeopordized in any way because it is not income producing—this would undermine the basic philosophy of the Mental Health Act. Thanks to our legislators this much needed social change was badly needed. In light of the fact, that our world is getting "smaller and smaller" and our urban areas problems more and more critical—it would be foolish to get rid of a resource or in fact curtail a unit of service which has and will keep on providing alternatives to the many problems prevalent in urban areas. We can stress strongly enough—that our legislators must find a way to provide funds for this service although it cannot provide "income". Perhaps, after Congress does its evaluation they may be able to provide us with alternatives to funding thru third party payment—by appropriating the needed funds thru the Federal government.

For the record, we also wish to state that after checking with Mr. William Wilmhn (of Mr. Hastings office) that upon checking with the Senate Committee that the reason why Consultation & Education was singled out was because the Senate Committee recognized the fact that according to present insurance company's data there is no way this category can be reimbursed by third party payment.

The reason why the House of Representatives did not appropriate any money was because they wished to maintain the law without any substitute change until Congress goes thru an evaluation of C&E during the next year.

Just at this moment, we heard the wonderful news that President Nixon has signed the Extension Act of the Community Mental Health Centers Act. We wish to convey our heartfelt thanks to our legislators who have chosen to give the proper priority to mental health in our nation.

May we impose on our legislators to really reach out to us—the community—to personally visibly assess the "need" for organizations such as the Community Coalition, Inc. These organizations have only really started to make "headway" in the field of mental health. They must be encouraged to continue and spread to each and every urban community in these our United States. The United States must never go down in history as shirking its responsibility to its citizens in the field of mental health—citizens should be encouraged to meet their own mental health needs.

Remember, we are literally demanding with all due respect that our esteemed and respected leadership in the Senate and House of Representatives support this testimony.

Mr. SYMINGTON. Thank you very much, Mrs. Sabino, for your very thoughtful statement.

We appreciate your giving it to us in a very precise form.

I might say for the record that H.R. 7806 was prepared with no cut-off curtailing or cutting anything but with an attempt to live within the 1973 appropriation and yet as far as possible to continue all the programs that were initiated under that or supported or maintained under that.

I wish we had more time to ask questions of the witnesses and I particularly wish to apologize to those witnesses who have not yet been heard.

I would like to suggest with the authority of our chairman, that we will leave the stenotype reporter here and I will ask Commissioner Miller to serve as a rapporteur to receive further statements and to conduct a panel discussion to the extent that it is deemed appropriate and necessary to do so to get all possible views on the record.

Then, when those documents have been prepared and submitted to the committee, we will make them a part of the full record, as if it occurred during our presence here.

For those of you who have come in since we began the hearing, this was the second oversight hearing of the Public Health and Environment Subcommittee of the Interstate and Foreign Commerce Committee.

Our chairman, Mr. Paul G. Rogers, of Florida, suggested—actually, he was responding to Congressman Hasting's request for such hearings because of the intensity of feeling here on this subject that we come today and this was before the leadership decided to hold a series of Friday sessions in order to push legislation along that line was beginning to get piled up.

The result is we now have to run for an airplane in order to get back to Washington in time to vote on certain appropriation bills which affect the country and you, too.

So, with that—and again, with great thanks to the witnesses who have presented their statements and those who have yet to do so, to Commissioner Miller, to Commissioner Christmas, who were so helpful—I will now adjourn the formal part of these hearings and turn the meeting over to Commissioner Miller.

[Applause.]

Dr. MILLER [presiding]. I am hardly a substitute for the Congressmen, but they are here through the record.

This morning, we not only will try to hear all of those who are scheduled to testify, but we will also try to keep the discussion as open and short as possible, so it can all be part of the record.

I don't feel I can do this alone. I would like to ask several people, and perhaps others as we go on, join me here, both to hear and to ask questions so we can help bring out all the points that should be brought out this morning. I wonder if Dr. Christmas would join me here and Mrs. Hathaway from the Mental Health Association, and also Irving Blumberg.

I want everyone in the room to feel free. We will try to provide an opportunity for people to ask questions within our time limits of those who are testifying, again with the particular point that all of us may have something to say but often to reinforce what has already been said to try to be sure that we do because I think the record is carefully read and noted.

It is not so much to reinforce only what has been said, but to insure that all points that we want to get into the record get in. Our questions will be primarily on emphasis.

I would like to call now on Rev. Orion Hutchinson, Jr., who will speak for the National Association for Mental Health.

STATEMENT OF ORION N. HUTCHINSON, JR., CHAIRMAN, COMMUNITY MENTAL HEALTH CENTERS COMMITTEE, NATIONAL ASSOCIATION FOR MENTAL HEALTH

Mr. HUTCHINSON. Thank you, Mr. Chairman. There has been prepared a written statement and copies of it were placed on the table up there. I don't know whether the Congressmen took all the copies with them or not, but this is the formal statement which was planned for presentation this morning and which I would again suggest be entered into the record if you could pass that request on to the proper persons.

Rather than reading that document after introduction of myself for the record, I will try to summarize some of the more crucial points within the testimony.

My name is Orion Hutchinson, Jr., by vocation, I am a United Methodist minister, specifically, superintendent of the Greensboro, N.C., district of the United District Church, which is served by Representative Preyer, who is a member of this committee.

By avocation, however, I am a volunteer in the mental health movement and have been for a number of years serving offices in the associations for mental health on the county, State, and national level. At present, I am chairman of the Community Mental Health Centers Committee of the National Association for Mental Health, of which the New York association is a part.

Any proposals relating to legislation for the future must be done against two backdrops. The first is the 1-year renewal action, which now lies on the President's desk which we, too, hope will be not vetoed and placed into law.

At the risk of being repetitious, we, too, are most grateful for the initiatives taken by Congressmen Symington and Hastings in this regard.

The second thing that serves as a philosophical backdrop for future legislation is the attitude of the administration. That attitude has been expressed in part through the sentiment that the community mental health program was designed to be a demonstration program.

What has really been demonstrated is not that community mental health centers are a valid therapeutic concept, but equally important that community mental health centers can be initiated and can become a valid therapeutic concept through Federal initiatives. This is the part that the administration sometimes overlooks, and we would want to affirm.

To fail to recognize this, to fail to recognize the essential nature of Federal initiative in terms of establishing community mental health centers is to fail to understand that nature of the problem and the forms of paralysis that have existed for generations in terms of community treatment for mental illness.

A second part of the administration's stance is the position that community mental health funding can come through other sources such as national health insurance.

Again, no legislation has been enacted yet nor may be enacted in the immediate future which will provide either national health insurance or provide adequate coverage for mental illness through national health insurance. This is a futile hope.

To withdraw Federal financial assistance on the basis that this would take its place would be to leave a vacuum, not to be filled in by any adequate support. There also is a concept that the Federal program in relation to community mental health centers has resulted in certain inequity.

For instance, an inequity of funding, some States receiving more than others, some locales receiving more than others whereas some went without anything.

A corrolary to that, not necessarily a product of the administration, but reflected through Nader's report and other evaluations which have taken place, is that centers have not served the poverty areas or the poverty people in the areas for which they were especially funded to serve by proverty grants or supplements. This may be and indeed is in some places a valid criticism.

In terms of future legislation against these backdrops, I would like to make a few points in simple catalog fashion.

First, there definitely needs to be community mental health renewal legislation, and we would like to see it done with at least the same basic 8-year funding program. We believe that it has been demonstrated that other sources of income, of revenue will pick up significant portions, but that they will only in rare instances do the initiation

The administration has suggested in part, community health centers could be funded in part through revenue sharing. The invalidity of this argument is on the basis of history. There have always been available tax revenues, but tax revenues have rarely gone for really extensive mental health efforts unless there has been strong pressure and personal commitment to this on the part of the legislators.

This is generally not the case. The Federal initiatives have resulted in response on the part of citizens who have pressed into use these Federal funds to bring about services and legislators who have been sensitized to the problem because of a possible answer upon the horizon which they saw through Federal initiative. So we push for the renewal and we recommend the 8-year base for funding.

We would further recommend the continuation of the present percentage formula for funding. There is a Senate proposal which has a different set of percentage figures. We feel that in this proposal the figures are smaller than is needed and also reduce at too high a rate, that is, the percentage drops much more rapidly than the present legislation. We feel that the present formula is a good one.

We would further add, and this links on to the previous testimony, that after the 8-year period, we would hope that consultation and education services would be funded on a continuing basis at 100 percent of the allowable budget.

We would further recommend that legislation be structured in such a way that renovation of facilities or leasing of facilities can be used but that construction would not be ruled out as an option. The important thing, however, is that we not be limited to construction in terms of establishing community mental health center facilities.

We would hope that continued attention would be given to serving the poverty areas, the poverty persons through supplemental fundings.

But we would further urge another point which ties into that and that is that the evaluation process be strengthened. A part of that evaluation process should be a method of determining those centers receiving special poverty fundings are serving the persons for which they have received these special or these enlarged grants.

Furthermore, we would like to see this evaluation process involve citizen participation, consumer participation. We would like to see it strengthened so that whatever deficiencies have surfaced in community mental health services programs can be dealt with, not in the prices of having to seek their fiscal preservation, but on the annual basis of seeking to do the job for which they are called to do.

We would like to suggest that considerations be given to a maximum amount which would be appropriated to any given centers based on perhaps a per capita figure. The reason for this is to get at the argument expressed earlier that some places have been more fortunate than others in obtaining funds.

It is true where there is a medical center, for instance, with a strong medical interest and a strong medical-political know-how that large grants can and have been obtained.

This is not to say they have been misplaced or misused. But it is to suggest if the funding is going to become more limited, then some mechanism needs to be employed to see that those funds serve as many different communities as possible and bring about initiatives for new services in as widely scattered and diverse areas as possible, especially the areas of grant need but only a little medical-political know-how.

These are some of the points which we would like to see studied in terms of future legislation.

I would simply add in conclusion that we stand perhaps at a point in which we have come through a moment of shock by the discovery that we might loose all funding, and now we are in the period of a brief respite for reexamination of where we are and where we ought to go.

The worst possible thing that could happen would be for us to go back to where we were before the Community Mental Health Service Act was ever enacted, to the time when essentially the only form of treatment was either beyond our sight or out of sight of mind in large State institutions.

The Community Mental Health Act has made treatment attainable and for goodness sake, let us use this period of shock to cause us to think clearly about where we ought to go and beyond that, to be sure that we keep on going.

Thank you.

[Mr. Hutchinson's prepared statement follows:]

STATEMENT OF ORION N. HUTCHINSON, JR., CHAIRMAN, COMMUNITY MENTAL HEALTH CENTERS COMMITTEE, NATIONAL ASSOCIATION FOR MENTAL HEALTH

My name is Orion Hutchinson. I reside in Greensboro, North Carolina, where I am Superintendent of the Greensboro District, United Methodist Church. I am Chairman of the Community Mental Health Centers Committee of the National Association for Mental Health, and I serve on the Association's Public Affairs Committee. I have served on both the Executive Committee and Board of Directors of that organization, in whose behalf I am appearing today.

The National Association for Mental Health is the national citizens' voluntary organization working toward the improved care and treatment of the mentally ill; for improved methods and services in research, prevention, detection, diagnosis and treatment of mental illness; and for the promotion of mental health.

I have been an active citizen-volunteer in the field of Mental Health for seventeen years. I have served as President of the North Carolina Mental Health Association and have been President of the Davidson County Mental Health Association in North Carolina. I have also served as a member representing citizen-laymen coucerns and interests on the following bodies:

State Legislative Council (Vice President).

Thomasville Chamber of Commerce (Vice President).

Board of Education, Thomasville, North Carolina, School System.

Our Association is very pleased that H.R. 7806, the legislation which was introduced in the House, passed by the overwhelming vote of 372 to 1. This important measure will permit the Congress time to thoughtfully review the CMHC Act and make appropriate changes.

We are very concerned with the Administration's position which would discontinue funding of new CMHC's. The rationale given hy the Administration regarding why they have chosen this approach raises more questions than it answers. We would like to address our opening remarks to the CMHC concept; give our answers to the Administration's position regarding renewal, and provide information regarding changes we recommend in the current CMHC Act.

The Community Mental Health Center is a health service delivery system already Federally funded in more than 500 communities in which approximately 35% of the Nation's population lives. It embodies many of tiie attributes held in highest regard by the present Administration. Yet, the Administration proposes to discontinue further Federal support with a seeming disregard for whether this system which it has praised can in fact survive the sudden withdrawal of support.

The attributes of the Community Mental Health Center system include:

1. Comprehensiveness—It encompasses within a single system all of the related services availahle to serve the population for which it is responsible.

2. Coordination—The services contained in this system are organized into a continuum enabling the patient to move freely and easily from one service to another as needed without the duplication of effort and cost present when services arc unrelated and uncoordinated.

3. The Program is designed to serve the total population of its designated geographic area. It is not a program developed specifically for the poor or any other class within the community.

4. The funds allocated go almost entirely into services for the persons in need. Very little money is used for the support of a bureaucracy.

5. There is a high degree of local responsihility. Controls and direction are provided by local volunteer boards.

6. The Center Program, which was to be initiated in each catchment or population area with Federal funding on a diminishing basis has moved steadily toward ultimate support by state and local government and private sources. Only ahout 30% of the money invested annually in operating the Community Mental Health Center Program now comes from Federal funds. 44% comes from local and state government; 20% comes from patient fees and forms of insurance.

7. The Program is not one which was developed and put together hastily in response to a crisis, but evolved out of ten years of thoughtful deliherations with extensive community planning at state and local levels. The planning process was initiated during the Eisenhower Administration, and the Program has had the continued support of each Administration since.

8. The Center system is designed in snch a fashion that it is compatible with any proposed comprehensive plan for totai heaith care deiivery and thns might be joined as an aiready operating component.

9. Despite commonly heid false assumptions, mentai heaith services are demonstrabiy insurabie within a pian of Nationai Heaith Insurance.

10. The Center System encourages community care with a minimnm of institutionai confinement which means that to the extent possible, the patient is responsibie for the fuifiilment of his own treatment pian which continning as a seifreiiant, tax-paying member of the community. The Community Mentai Heaith Center has aiready piayed a major roie in the reduction of state hospitai census by a dramatic 36% in the iast five years, in closing a number of state hospitals in severai states and in making a sharp reduction in the amount of funds expended in the construction of new institutions.

11. The Center system piaces major attention on the deveiopment of a preventive approach with better and more efficient utiiization of iimited professionai manpower.

Why, then, does the Administration propose to piace a program so much in accord with its own stated objectives in serious jeopardy by the ahrupt termination of its financiai assistance? Severai reasons have been offered for its action:

1. *The Program was intended to be a demonstration. It has now been demonstrated to be successful and effective and should therefore be picked up by funding from other sources.*—The probiem iies in the definition of "demonstration". It is ciear that those who wrote the originai iegisiation did not intend that Federai support would continue undiminished and forever. Funding grants were to be for a term of eight years and provision was made for diminishing Federai participation during that eight-year period. Thus, Federai funding was to serve a pump priming purpose. It was aiso to demonstrate to each commnnity the merits of the program and the capabiiity of each community to pick np graduaiiy the financing of its own center. Congress set as its goai that a mentai heaith center shouid be established in as many catchment areas as necessary to serve the totai popuiation of the country. It was not the intent of Congress when the initiai iegisiation was enacted to assist a few favored communities to have centers and then to ieave to chance the spread of the program eisewhere.

2. *The Program will be funded through National Health Insurance.*—Unfortunateiy, Nationai Heaith Insurance does not yet exist nor does it seem imminent. In addition, it must be recognized that even if Nationai Heaith Insurance might snpport the continuation of an existing Community Mentai Heaith Center, it wouid not, as a fee-for service mechanism, provide the funding for consuitation services, which are a major component of the preventive function. Nor would insurance provide funding for the initiation of new and needed centers where they do not aiready exist.

3. *The Program can be supported and Centers can be initiated through revenue sharing.*—Without debating what may prove to be the eventfui virtues of the revenue sharing approach to Federai participation in iocai programs, there seems to be a caiious disregard for reaiity in proposing this soiution. There is no evidence that revenue sharing will be so effective immediately that each of the many programs which apparentiy are expected to derive their support from this source will each receive its equitable share without interruption of service and irreparable damage. Neither can anyone be sanguine abont the prospects of equitabie consideration in the intense competition which will take place not oniy between estabiished programs but aiso with those which may be opportunisticaiiy devised in response to state and iocai speciai pressures. Further doubts arise concerning revenue sharing as a soiution because of the tendency on the part of state and iocai governments to use the funds shared with the mfor onetime capitai expenditures rather than for programs involving long-term financiai commitments. Then, there are indications that aii the programs which are supposedly to be supported by revenue sharing are going to have to be financed with what appears to be iess doiiars than are currentiy available through present funding arrangements.

Finaiiy, we are deeply concerned about an approach to financing which does not provide for a continuing Federai regulating reiationship. Though a substantiai part of the funding may come from other sources and though program control and management may be iocai, uniform standards of practice and performance estabiished by the Federai Government are highiy desirabie.

4. *The Federal grant program for Community Mental Health Centers has resulted in an inequitable distribution of services with certain states and the communities receiving a disproportionate amount of the funds available.*—It is true

that some states were better prepared to move ahead than others and have attained a more rapid and complete coverage of the popniation of their states. It hardly makes sense, however, to deprive those states which have been confronted with greater difficulty in proceeding simply because the funds have been inequitably distributed to this point. To do so would be to perpetuate the inequity.

With due regard for the concerns of the Administration as expressed explicitly and implicitly in the reasons given for discontinuance of Federal support, there is still an important role which can be properly and appropriately played by the Federal Government.

We believe the following four recommendations are realistic in terms of Federal government involvement in the Community Mental Health Center Program and its development to the high level of its potential.

1. That Federal funding continue for the purpose of assuring the initiation of a Community Mental Health Center in each of the 1500 catchment areas required to encompass the total national population. Presently, there are 493 centers Federally funded and a small number financed in other ways. This means there are at least 900 catchment areas for which centers must still be planned and initial funding secured. Continued Federal participation should at least make available an initial eight-year staffing grant for the support of a properly designed and approved mental health center in every catchment area still unserved by such a center. June 30, 1980, should be regarded as the target date for comprehensive national coverage with initial staffing grants.

2. That a ceiling be placed on the amount which can be allocated to any one center in order to avoid giving undue advantage to those having unusual grant-writing skills and in order to provide for an equitable distribution of available dollars to all catchment areas. Such a ceiling should be based upon a formula taking into account appropriate variables to be established by regulation.

3. That there be a continuation of preferential funding for centers serving poverty areas with the requirement that the additional dollars allocated to such preferential funding be used for the provision of services to the poverty population.

4. That long-term funding beyond the initial eight-year grant period be available to finance consultation and other preventive services not normally reimbursable from other sources. Preferential funding should also be available to support such services in poverty populations.

The National Association for Mental Health has respectfully requested that the Administration, acting in good faith and in a manner consistent with its avowed endorsement of the Community Mental Health Center system, adopt the above recommendations and enter into communication with appropriate members and committees of Congress as necessary to achieve a satisfactory settlement of divergent positions held by the legislative and executive branches of government.

In conclusion, it is our position that the CMHC legislation should be modified, taking into account the need to use federal funds to assure that "seed-money" is available to each of the 1500 catchment areas throughout the country. We believe our recommendations will achieve that end.

Dr. MILLER. Mr. Hutchinson, thank you very much for your detailed comments and your resolve.

I think perhaps in the interest of time and because there are so many waiting to testify, we will go on with the others who have testimony to present; but we will try to reserve some time perhaps to recall some of those who have already testified. I am sure there are some questions. Your presentation was extraordinarily complete.

I would like to call next Mr. Max Schneier, who is the chairman of the New York State Federation of Parents' Organizations of State Mental Institutions. Mr. Schneier.

STATEMENT OF MAX SCHNEIER, CHAIRMAN, FEDERATION OF PARENTS ORGANIZATIONS, NEW YORK STATE, AND VICE PRESIDENT, CITIZENS UNITED FOR THE HANDICAPPED

Mr. SCHNEIER. My name is Max Schneier and I am chairman of the Federation of Parents Organizations for the New York State Mental

Institutions and vice president of Citizens United for the Handicapped.

I come before you today as a representative of those people who have the greatest vested interest in the delivery of care and services to the mentally handicapped through their community mental health centers, namely, the parents and relatives of those so disabled. This hearing is an example of the American process at work—legislators listening to the people to ascertain their needs and then taking the information gathered and translating it to beneficial and corrective legislation. We parents wish to thank this subcommittee for this opportunity. Your evident interest and understanding of the problems afflicting 20 million of our citizens bodes well for the enactment of future legislation to provide the help and programs needed by this large segment of our population.

In addition to the 20-million figure mentioned, there are 9 million Americans who are problem drinkers or alcoholics and 600,000 heroin addicts.

I come here to tell this committee to take this message back to our Nation's Capital, and that message is, "No force on earth can stop an idea whose time has come." That idea, whose time has come, is the ongoing involvement and participation of the patients, parents and relatives in the planning for and the execution of the programs for care, services and rehabilitation of the mentally handicapped. The consumer of mental health services movement gathers strength with each succeeding day. We are being aided almost daily by favorable court decisions throughout the Nation. We have developed dedicated leaders who have pledged themselves and their resources to continue the struggle until our Nation reorders its priorities and places human priorities before all others.

This is no flash in the pan. We will not go away and disappear or be lulled into a false sense of security by politicians' promises, which never come to fruition. We have become knowledgeable because of our pain and suffering and the daily burdens we must carry, we are organizing so that we may gain the victory which will redound to the benefit of our handicapped fellow Americans, who today are dehumanized and debilitated in the large, custodial institutional warehouses operated by all the States, or who have not been able to find alternative community facilities such as the community mental health centers. The Congress of the United States has, by its inaction, permitted these crimes against humanity which have no parallel in our American history. The Congress has, in prior years and for the most part, left this problem to the individual States. The States, in turn, have consistently demonstrated that they cannot and will not fully meet the needs of the consumers of mental health services. Mental health is in essence, a national problem and the direction, programs and funding must mainly come from Washington, and not the State capitals.

I am sure you are well aware of the statistics and the growing need in this vital human area which costs our Nation $20 billion a year in lost productivity. You all know that every other hospital bed in this country is occupied by a mentally disabled person. I have previously referred to the large numbers of our citizens who are in need of services. You know that our elderly are particularly affected by mental

illness and that this group makes up 20 percent of the elderly living at home also suffer some mental impairment. Most of us here know that the resident population in our State mental hospitals has dropped markedly—from 558,000 in 1955 to 276,000 in 1972. It is ironic that HEW officials concede that the community mental health centers programs have contributed to this drop. We are aware of the fact that federally funded centers treated about 1 million patients in 1972 at less than one-tenth the cost per patient-care episode than in large State institutions and that these centers keep in-patients care on the average, to under 20 days, returning patients to work more quickly than State institutions.

With all of these incontrovertible facts at our disposal, why is there any question as to the need, not only of continuing these programs, but in fact to increase the number of community mental health centers from the present 493 to the 1,500 originally contemplated by the Congress. We have support of usefulness of these centers from none other than our Secretary of Health, Education, and Welfare, Caspar Weinberger, who recently wrote to the executive director of the National Council of Community Mental Health Centers as follows:

You are completely correct that I have no disagreement whatever with the value of the community mental health center program. . . . As one who had something to do with the start of the mental health idea in California, before there was Federal funding, I have no question as to the immense usefulness and effectiveness of the community mental health center idea.

Yet, there is an absurdity in the present administration's position in regard to the community mental health center program. On the one hand, the administration—both in the President's budget proposals last January and in testimony before congressional committees—has indicated that the community mental health centers program has been highly successful.

On the other hand, the administration proposes terminating Federal support without presenting any reasonable alternative source either to support existing programs or to initiate new ones. The administration's arguments for discontinuing support are:

1. The original intention of the Community Mental Health Centers Act of 1963 was just to provide seed money to start the centers and subsequently for the Federal Government to drop out of the picture, that these centers were only demonstration projects. Our answer is that every new program was a demonstration project when it was first initiated.

2. The community mental health centers have been so successful that no new funding is necessary. The administration wants to end other major health programs, the regional medical programs for instance, because it contends they have been failures. But curiously and I say stupidly, the mental health program has lost administration favor because it has done so well.

The chairman of your subcommittee, Representative Rogers, in commenting on this absurd situation has stated the administration policy evidently is, "If it is good, do away with it. If it's bad, do away with it. In other words, wipe out all activity, and I think that that may be what is what they want to do."

Chairman Rogers further stated in his remarks on May 2, 1973, before a mental health group that: "The whole purpose of the pro-

gram—community mental health centers program—was to treat the mentally ill in their local areas rather than yank them out of their communities and put them in a warehouse."

He further charged that the administration was abandoning the program before it was one-third of the way toward its legislative goal—1,500 centers across the country. In agreeing with the contention that the cutting down of Federal support of the community mental health centers will not have money in the long run, because States will have to pay for increased use of State mental hospitals, where treatment is more expensive, Chairman Rogers further stated: "This is not a buck-saving budget, but a buckpassing budget."

3. The administration argues that the programs are inequitable in the Nation as a whole—ranging from total implementation in all catchment areas in Kentucky to many States which only have a very few community mental health centers and therefore it is not, "a proper Federal role," to continue to support direct mental health care services for a few.

The logic of this argument escapes me completely. It would be easier to follow if Secretary Weinberger, who advanced this particular argument, would have stated that it therefore was mandatory for the Federal Government to implement an orderly program to reach the legislative goal of one community mental health center for each of the Nation's 1,500 catchment areas. Senator Harold E. Huges charged, "It looks to me like they have adopted a policy of reducing inequality by reducing services to the lowest possible level at all points."

4. It is up to the States or other funding sources to pick up the Federal share of mental health center funding. The HEW however formally admitted that it had no concrete information that the States would pick up the funding or that other sources could or would do likewise.

As for the contention that third-party insurance payments would begin to pick up more of the center's costs, it is becoming clearer that third-party insurance payments will never be a factor if 42 percent of all persons using the centers have family incomes below $3,000 per year and 62 percent have family incomes below $5,000.

These disadvantaged people could never afford any insurance costs for such protection and therefore do not have any. As for medicaid and medicare—many States do not cover mental health services in their medicaid programs and medicare payments are necessarily restricted by the fact that they cover the elderly.

If private insurers cover mental health services at all—and many of them do not, or the coverage is extremely limited—particularly on an outpatient basis, high coinsurance payments usually are required.

As for future national health insurance payments to pick up the necessary funding—such a plan will not be operable for at least 3 to 4 years and all such plans now being mulled over have restrictions as to the coverage the mentally disabled will be able to get from such insurance.

Because of the distant future of the realization of national health insurance, and because of its limited coverage, it cannot now be considered as an alternate source of funds for community mental health centers.

As for general revenue sharing, experience to date indicates that a very large proportion of these funds are being used by communities and States for capital improvement purposes rather than for human services.

In any case, the competing demands on these funds at the State and local levels are such that their availability for community mental health programs will be limited. Pointing out this conclusion more graphically is the survey made by the National Council of Community Mental Health Centers which found that only 22 centers had received financial aid from revenue-sharing payments, and in most of these 22 instances the amount of assistance was less than $5,000.

As for the availability of State and local funds, the competing demands for use of State and local funds are such that it is unlikely in the foreseeable future that significant moneys from these sources could be used to continue support of mental health centers or initiate new ones. At this point of time the States are already contributing more to the cost of community mental health programs than the Federal Government is. This has been true since 1963. Certainly the States would not be able to pick up the $200 million per year now provided by the Federal Government and the $400 million more in addition that would be needed to implement the legislative intent of 1,500 community mental health centers.

For all of these stated reasons the Federal Government must not and cannot disassociate itself from supporting the existing community mental health centers program and from taking the leadership in initiating the 1,000 new ones which are so desperately needed and which will prove their cost effectiveness in the years to come.

In a heartless statement of the current HEW philosophy, Secretary Weinberger has offered the thinking that if programs cannot make it on their own without Federal assistance, they should not be perpetuated by Federal aid—regardless of their importance to health care in the country.

We parents and relatives feel that the various responses to such a callous philosophy from responsible leaders of the Senate and the House of Representatives will not permit this thinking to prevail. Congressman Hastings set the tone for congressional thinking in this area when he stated, "My introduction of this legislation, H.R. 5608, should not be construed as a personal endorsement of all of these programs, but rather a necessary mechanism to permit the Congress, which established this authority in the first place, the necessary time to make a responsible evaluation and decision."

Chairman Rogers told HEW Secretary Caspar Weinberger when he testified before his subcommittee: "This subcommittee will not condone dismantling of existing programs until Congress decides whether these programs should be continued, should be modified or perhaps, terminated. It is the Congress that will determine their fate. I believe that the current programs should be held in place until the process of review and evaluation through hearings and the development of new proposals in the form of public law, can be completed. The administration and the Congress should work together toward this end." Strong statements in support of the continuation and expansion of the community mental health centers program have also been made by Senator Kennedy, Senator Schweiker as well as many other Congressmen and Senators.

The present status of the federally funded community mental health centers program leaves much to be desired and all of the demonstrated deficiencies and needs must be adequately cared for in any subsequent legislation. I have pointed out that only 493 of the country's approximately 1,500 catchment areas have community mental health centers. The 493 catchment areas account for less than one-half of the population in this country. It is clear that without the continuing leadership role, the incentive provided by Federal funds, many of the remaining 1,000 catchment areas—especially those in rural and urban poverty areas—are extremely unlikely to develop the type of comprehensive program which is the earmark of this highly successful approach to the delivery of mental health services.

In the 493 catchment areas, we now have the reasonable expectation that patients with emotional problems will receive comprehensive services; that the services will be available and accessible to them; that the services will be tailored to the particular need of the geographical or cultural area; that continuity of care will be ensured; and that both preventive and treatment programs are in operation.

The National Institute of Mental Health has on hand 78 approved but unfunded staffing grant projects totaling $38 million. The President's revised fiscal year 1973 budget prevented payment of any of these grants. In addition, the NIMH was ordered, earlier this year, to stop the process of reviewing applications because of the President's decision not to support any new projects. Thirty-three such applications for $12.9 million is grasts have been returned by the NIMH since it stopped taking applications in late February 1973. "In the pipeline"—or being processed in regional centers—were 96 applications for an estimated $43 million in grants.

Of particular interest to us is the area of children's services. At the present time, 150 of the operating community mental health centers have a comprehensive specialized service for children but another 270 centers do not have such a component. In the children's area—Part F under the amendments of 1970 to the act of 1963—11 projects were approved but could not be funded by NIMH during this fiscal year. These last points are issues of an appropriation rather than of an authorization nature but I would strongly urge you and your colleagues to ensure that the fiscal year 1974 budget, which will be acted on by the Congress this summer, includes the maximum funds provided for under the 1 year extension of the community mental health centers program which was just enacted by Congress.

While we would be the first to assert that the mental health centers have not been uniformly successful, that Federal monitoring could be improved, that new legislative language is needed to bring about improvements in the program, we whole heartedly support this program and strongly urge its continuation. It seems to us that the administration's very substantial praise of this program provides the most persuasive argument for the continuation of a major Federal role.

The criticisms leveled in July 1972 by the Ralph Nader—Affiliated Center for the Study of Responsive Law—should also be studied by the committee for any appropriate corrective action they deem necessary. These criticisms were mainly leveled at management inefficiency; conflict between the clinical, medical, and social service approaches; responsiveness to the community; and better oversight by the NIMH.

They should all be targets for discussion when Congress reviews the community mental health center program.

We parents and relatives want to avoid creating another mental health bureaucracy, which would be dominated by psychiatrists and which would be unresponsive to the lessons learned from treating the mentally disabled in our State mental institutions. We also do not feel that the community mental health centers should keep a low profile in the community to avoid being swamped with patients. We do not want solely adopted a clinical treatment approach which would neglect the important supportive social services. We do not want to have the mental health professionals spend as much time on administration as they do on patient care. Such administrative duties should be left to management specialists. We want redoubled efforts to assure services to the poor and the minorities. And above all, we want much more community participation in a center's decisions. No decision, which affects the vital interests of the consumers of mental health services, should be made by any center without the participation and involvement of the community in the decisionmaking process.

We therefore recommend the following action:

1. Legislation must be quickly developed and enacted by Congress prior to the end of the first session later this year. This legislation should provide for at least a 3-year extension of the community mental health center program. In the absence of such legislation we will be faced again next spring, with an 11th hour struggle to continue the program. This is an impossible state of affairs for the hundreds of communities throughout the country that are most anxious to develop comprehensive mental health programs but are cautious about moving in this direction because of the uncertainties of Federal funding.

2. Any new legislation in the community mental health center area should address itself at least to the following critical issues:

(*a*) How will the direct patient care service—inpatient care, outpatient care, emergency services, partial hospitalization—be covered prior to the enactment of national health insurance?

(*b*) How will these direct patient care services be covered subsequent to the enactment of national health insurance?

(*c*) How will the important indirect services, consultation and education, of a public health nature be covered prior to and subsequent to national health insurance?

(*d*) What provisions will there be to assist communities with "start up" costs prior to the enactment of national health insurance?

(*e*) What provisions will there be for assisting communities with "start up" costs subsequent to the enactment of national health insurance? It is reasonable to expect that national health insurance will cover a large part of the direct patient care costs, however, it is unlikely that national health insurance will cover either the indirect public health activities or the critical "start up" costs.

(*f*) The Congress must insure appropriate coordination of community mental health services with services in State, county or city mental hospitals and universities. Some means must be found to assist in the development of a single system for the delivery of mental health services in which the community would be involved and in which they would participate as equal partners.

(*g*) Future legislation should increase the extent to which a variety of rehabilitative services—especially those of a vocational nature—are integrally related to, if not part of, community mental health programs.

The people of the United States, including the hundreds of consumer organizations in all of the States, as well as national consumer groups such as the National Association for Mental Health, the National Committee Against Mental Illness, the National Council of Community Mental Health Centers, et cetera, and the national professional groups such as the American Academy of Child Psychiatry, the American Psychiatric Association, the American Psychological Association, the National Association of Social Workers, et cetera, are deeply committed and dedicated to this program and can mobilize a great deal of support at the grassroots level in every congressional district throughout the country to help insure enactment of any new community mental health centers legislation that is brought out of your subcommittee. We stand ready to provide any assistance which you may ask of us.

Thank you.

Dr. MILLER. Thank you, Mr. Schneier, for your cogent and forceful remarks.

Let me state in passing that I recently heard a report on mental health services in Japan. Everybody there is covered by some type of third-party insurance for psychiatric care, but there is nothing there which resembles the structure of mental health centers and it is the only developed country in the world, I am told, where the number of residential beds for psychiatric patients has increased rapidly.

I would like to call next on Dr. Robert Campbell from the American Psychiatric Association.

STATEMENT OF DR. ROBERT J. CAMPBELL, SECRETARY, AMERICAN PSYCHIATRIC ASSOCIATION

Dr. CAMPBELL. My name is Robert J. Campbell, and I represent the 3,100 psychiatrists of the 14 district branches of the American Psychiatric Association in New York State. We are grateful to the Congress for its continuing concern for the health of all our citizens, and especially for its successful action in extending the Community Mental Health Act. We are also grateful for this opportunity to express our views on the contents of future Federal legislation related to community mental health services. We would not ask, nor would we expect, that ours be the only voice heard by those who will draft that legislation. We would rather hope that the following recommendations be given serious consideration at each step of the deliberations on the future of community mental health centers.

We suggest, first of all, that a facility grant program replace the construction grant program of the current act. Such a step will promote the use and renovation of existing facilities and will accordingly reduce expenditures for nonessentials: It will appropriately emphasize programs, not the bricks and mortar that house them.

Second, we favor operating grants rather than staffing grants, so that a proportion of the entire cost of operating a community mental health center can be funded. This seems to us more workable and

practicable than an arbitrary division into direct services to patients on the one hand, and all other supporting services and staff on the other.

Third, each community mental health center should be required to develop a plan that will guarantee an appropriate range of services for elderly persons, for children, for alcoholics, and for other drug abusers. The argument that one catchment area does not generate a caseload heavy enough to warrant such comprehensive programs is too often used as a way to evade all responsibility for such neglected groups.

Fourth, each center should be required to develop and maintain an effective working relationship with the State hospital to which it relates, so that appropriate screening of patients before admission to a State hospital and aftercare following discharge from a State hospital can be provided within the catchment area.

Fifth, continuous evaluation of community needs and of the extent to which services meet those needs must be required of each center. Ongoing and independent analysis of program effectiveness by the Department of Health, Education, and Welfare or NIH, NIMH, whichever is organizationally appropriate, should also be mandated.

Sixth, priority in awarding funds should be given to catchment areas which are not yet serviced by community mental health centers. To encourage timely development of needed services in areas that lack ready access to planning staffs— that is, areas relatively unsophisticated about "grantsmanship"—the granting agency should be directed to assume an advocacy consultative role in developing grant requests insofar as such assistance is acceptable to the catchment area concerned.

Finally, support to all funded centers should be extended until such time as national health insurance, other federally funded health service delivery programs, such as HMO's, or other third party payment mechanisms can begin to assume the costs of the centers' services.

Thank you very much.

Dr. MILLER. Thank you, Dr. Campbell, for very useful testimony.

I would like to call now on Mrs. Betty Still, president of the Jamaica-Flushing Mental Health Council.

STATEMENT OF BETTY STILL, CHAIRMAN, JAMAICA-SOUTH FLUSHING MENTAL HEALTH COUNCIL, QUEENS, N.Y.

Mrs. STILL. Thank you, Dr. Miller. Good morning, Dr. Christmas and other friends. This is my first time to appear before you and since you said there was some opportunity for folks to speak, I thought I would get my name in.

I am a consumer, a layman, the chairman of the Jamaica-South Flushing Mental Health Council, of which I believe you have heard.

We have been in the process of working on a grant for the last 4 years. Two of those years, I have been the chairman. Our grant was received, adopted, what have you, but it was never funded.

As a layman, I really cannot understand that if you follow all of the guidelines, If you run to Albany or to Washington, if you send letters into the different offices and then you come back and you say

we receive a letter that the grant was approved with no money, how can you really set up a center and how can you really service people?

Again, as a layman, I say how do you go out into the community and say please come over and support our grant. We have it approved, but we have been waiting for the last year to receive funds. Now, how do we go back to explain? How do I go to the council now to explain to them and tell them why we cannot set up a center.

We do not have such a center in Queens, and it took quite a bit of time and energy to go into the community to explain to them that we do need this, and we want your support. The guidelines said we should have community input. You can not keep community people interested unless you show them something besides paper.

I think too much paper has been used and perhaps some building could have gone up and some staff had been paid if we stopped so much of the paperwork.

I feel there should be perhaps two or three sets of guidelines and then the community could use that particular guideline that they desire and then they could proceed on when it is submitted if by chance they have left out something then they would go back and take care of that, but, for Heaven's sake, after they have followed all the guidelines, I can not see why the moneys have not come down.

If you will, I would like for you to explain to me, not now, but maybe I could get something in writing so I could take it to the Council.

Why is it when we know there is a need and, of course, you know there is a need, the city knows there is a need, when you follow all of the steps, then you send back a blank piece of paper—there is no money. You really can't keep people interested.

Do you feel that people may have to tear down walls? Do you feel they should write on walls? Should they destroy buildings and then suddenly money is found to put up these structures to help people? Do you feel a person must really crack up and go berzerk in order to get something?

As a layman, I am asking this because I think I have worked rather hard as well as the rest of the people coming to meetings, uniting them, running downtown, running to Albany, going to Washington, and this is no paid thing. This is a voluntary thing and when I stand up and try to persuade others to do this because I feel that something will come through yet and after a year's time you don't see anything what do you tell people?

Do you say let's take this bus and turn it over in front of the commissioner's office and then they find money? Is this proper? I would like to know what do you plan on setting up for a community when you ask for community participation because we say 50 percent consumers—professionals may be a little more dignified in doing things—but when you are out here with the hard core community and you are trying to persuade them to do something, you have to show them something besides paper and pencil.

I would like to know if you can help me with this.

Dr. MILLER. I am glad that the record will include such a direct description and report of what it feels like to be involved in the development of a center which, as you described it, finally was approved, but not funded.

I wouldn't attempt to try to answer as if I were a Congressman, and I am not sure it is appropriate for me to turn this meeting into a discussion of other matters at the moment. But your experience is not unique, and that makes it all the more important that we have a record of that kind of experience which could be matched, I suspect, in a number of places.

The past extension of the mental health centers legislation might address itself to that particular center, but more would be required if the same situation is not to take place again in the fture. So I thank you for your testimony.

I would like to call now on Dr. Paster, director of the Washington Heights Mental Health Center.

STATEMENT OF DR. VERA PASTER, EXECUTIVE DIRECTOR, WASHINGTON HEIGHTS-WEST HARLEM-INWOOD MENTAL HEALTH CENTER

Dr. PASTER. Thank you. I think the timing is very appropriate. I am referring to the presentation of the previous speaker, because I have experienced the frustrations described. I would like to add a happier postscript in the context of this hearing.

The Community Mental Health Centers Act provided the thrust for a changed concept in mental health care that 10 years later is still in the process of being realized.

It takes time to change habits, behavior and thought patterns developed over many generations. In 1963 there were already years of asylums for the insane; years of hospital-based voluntary clinics for the emotionally disturbed, but each pursuing its own treatment goals for the selected few, rarely even recognizing the existence of the others; years of the entrenched interests setting the standards and determining the criteria that indicated who should and who should not be served; who should serve and who should not.

The remarks of the previous speaker are particularly relevant in this respect and the experiences that I would like to share with this committee follow up in the same vein. It seems to me that 10 years is not too much time to reconceptualize the theory of mental health or to bring about the skills to attain these new goals or to generate the courage, and the determination to do so. Required are a steadfast will and the processes to actually implement an expanded concept of health care that I believe was intended by the Community Mental Health Centers Act.

If it was the intention oft he act to reconceptualize the care of the mentally ill, if it was the intention to extend mental health care services and to involve the community, then we are still in the process of becoming.

With prior permission, and in the spirit of the content, I would like part of the time for my testimony to be shared by the chairman of our board, a community member. This examplifies the partnership that I believe is one of the intentions of the act.

The provisions of the community mental health center with its supervisory structure at NIMH has made it possible, and has given hope to community groups to activate themselves on their own behalf

I would like to refer to those I know best, the people in the Washington Heights-West Harlem-Inwood section of Manhattan in New York City.

This is a group of ordinary citizens, black and white, poor and middle class, people on welfare, people with jobs, professional people and lay people who have been banding together to look for alternatives for meeting their mental health needs.

In so doing, they are developing the concept. They are putting meaning into the concept of a program of mental health that is directly responsible to and responsive to the community. Legislation provides the thrust. The actual implementation takes dedication, work and struggle, accidents, mistakes and learning and doing.

I think that is what is happening in our area.

In 1968 several residents of Washington Heights learned that the entrenched training and research-oriented university medical institution in their area had been asked to develop a community mental health center. Because the Community Mental Health Center Act prescribes community input, that was the initial access. Thus, these persons, Mrs. Emma Bowman, Mr. William Hatcher, Dr. Reuben Mora, and others, felt encouraged to involve themselves.

They involved themselves to the point of asking to participate in the planning of the community mental health center. When this interaction escalated in conflict, the act itself was the force that legitimated the thrust of the community to have its priorities addressed.

All of this resulted in the community's being given the charge by the city and the State mental health departments to develop the community mental health center program for the area. That would never have happened had there not been that act.

The momentum provided by the potential availability of Federal funds to help financially provide for five essential services directed to their needs, generated an energy among this group of citizens that is increasing still 5 years later. This community is taking seriously the intent of the act and in so doing, is not putting a new label on an old bottle by calling an old medical care package a community mental health center.

The intent sought by the community and which is, in the attempt of being realized, is community involvement, preventive care, effectiveness and availability of service to those who need it most, coordination of programs and a comprehensiveness of the service for people who have need.

It has truly involved a large number of community persons. These people meet together regularly to learn about and to formulate their own concepts of mental health and mental health delivery services. They determine their own needs and interact with various segments of local government. They work with planning boards and neighborhood action programs, get out the vote, write to Congressmen, and become involved as active members who have something to say about what happens to them.

Many have been stimulated to return to school. People who may have dropped out of high school are going back to college and getting advanced degrees. They have addressed their energies to the means of

improving their community starting with mental health issues and extending to seeing that the streets are cleaner, and on to bringing in large programs of general health care, also to be addressed to the community's needs. They care, they show that they care. This, in turn, generates a force, a force of neighbors committed to each other and committed to improving life and demonstrating that there is some hope to do so. This makes for a mentally healthier community. I feel that this process in and of itself, is a great answer to mental health for the community.

Professionals employed by this community have no ivory tower. They are in constant interaction with the community and thus are enabled to program for the real priorities of the people.

They must seek out ways of initiating contacts and effectiveness and visibility in reaching those who suffer and preventing breakdowns and becoming a vital part.

The interaction between the paid staff and volunteers takes place at the monthly meetings, at the monthly board of directors meetings, and in committees in which community people work together with staff on specific programs, both in the center and out in the community.

This kind of joint force prepares the base for forward thrusts and makes for a mutual education that is the foundation of a real partnership.

So, we have the involvement of the people in their own mental health care.

What programs has this collaboration produced? I will give you just a couple of examples to convey the spirit of what an act of Federal legislation may look like on a very, practical local level.

One example is the generation of action coalitions directed toward a neighborhood menace, that was a single—room occupancy that attracted the poor, the disadvantaged, the miserable of the community and was a locust for all kinds of drugs, alcoholism, prostitution and crime. The people in the community were afraid of it and ashamed of it. But also those people who were activated themselves to care, cared also for the residents.

Ten agencies, including a broad range, for example, board of health, visiting nurses, drug programs, civic groups, the department of social services and so forth were brought together by the Washington Heights-West Harlem-Inwood Mental Health Council to plan forceful action to do something about this situation and to help the people in it.

The city machinery for dealing with these problems, was engaged and brought up to our area. The landlord was met with, contended with. The result of this was that he was forced to remove the building violations and he was persuaded to provide space for agency personnel to work right out of that building.

In addition to that, the composition of the residents of the SRO was changed. At this point, the aged, the physically disabled, the alcoholics, the drug abusers, are clients who are being worked with a variety of ways right on their own grounds.

Another program is operation doorbell. Here staff and community contacts a householder of an apartment houses, and with this person

canvasses each family in that building. Each family is asked to consider its needs and build on this increased awareness to get together with other families to discuss mutual concerns.

We have experiences of some neighbors having been neighbors for 20 years speaking to each other for the first time at these meetings which are held in lobbies of the buildings. There are frequently housing problems and other practical problems. We provide the staff support, we get the people in who can redress the grievances, and we help the tenants direct their thoughts beyond the immediate pressing urgency.

We are encouraging these housing associations to form block associations. We have experienced the success of people living in unhealthy, unsafe conditions for many years suddenly seeing that it is possible to physically change their surroundings.

We have seen block associations develop recreation programs for the youth whom they had considered to be menaces up to that time.

One more example: Under the leadership of the council, heads and some staff of every mental health and every human service agency in the community now know each other, talk to each other and meet regularly to plan and coordinate programs. This articulation of services is implemented by joint sponsorship of programs, by sharing staff ing within agencies, by task forces that we described before, and by other means.

For example, the State hospital has assigned staff to community agencies to facilitate aftercare services.

The council and the original training research-oriented university hospital are now cosponsoring a home for seriously emotionally disturbed adolescents as an alternative to hospitalization.

This community mental health concept has also shaped the kind of mental health care and the availability of care developed in the community.

The doors of the center are open from 9 a.m. to 9 p.m., 5 days a week. Informal contact is encouraged. All kinds of activities take place at the center. One can have one's needs met without having to undergo a complicated process.

It forces professionals to look for means of giving care other than those traditionally used, for example, group therapy around making clothing and furniture.

It pushes us to the streets to work with youths and youth gangs. It pushes us to the isolated rooms of the withdrawn. It makes us actively reach out to do what we are supposed to do, and to address the people to whom we are responsible if we fail to do so.

The fact of a Community Mental Health Service Act then has provided the resources to render the services that the community knows that it needs. This act demands not only to be continued, but to be expanded. It provides the impetus, it provides the energy, it provides the very practical financial support. It provides the force for people to begin to work together. We are only beginning to explore the vast potential of the actual technical means of fulfilling its goals.

I would like to now put a comma to this presentation, and have it continued by the other half of this partnership represented by Mr. Hatcher.

STATEMENT OF WILLIAM H. HATCHER, CHAIRMAN OF THE BOARD, WASHINGTON HEIGHTS-WEST HARLEM-INWOOD MENTAL HEALTH CENTER

Mr. HATCHER. Thank you, ladies and gentlemen, for giving me this opportunity to add to what our director has given us up to now. I would like to make one correction. She said 1968. That is taking about 18 months of energy and effort from us and I would like to put that back. It was much earlier than that.

I might say our organization is probably an accident, because at the beginning, we had no intention of taking the route we finally took. We merely wanted to have an input in the developing of the mental health center at that time, supposedly sponsored by the university in our community.

A conflict developed, of course, and we took another route.

To backtrack a little, I, myself, am a layman also. I have no background in health or mental health. I am in fact a merchant. I have been asked many times how does a merchant happen to be in mental health? I could add that I am in more than mental health. I am also in health. We are hoping to bring the health services in our area under the same terms that we were able to bring mental health.

They both fit in the same category in that we have no local health services and we had no local mental health services.

To get back to why I am here, Mrs. Bowen mentioned by the director, happened to be appointed to a job called the executive secretary of the then Community Mental Health Board. She and I are very friendly. We both recognized that she had been appointed merely out of the fact that she had been a politically active person in the election of the mayor.

We determined that it would be more than just a political appointment, because the guidelines said she was to, as I remember, "alleviate the stigma associated with mental illness." She had no idea or anything about how to go about this. Mental illness or mental health to us meant people incarcerated in hospitals. She requested my assistance and I gave it.

In the process, we started to bring people together, something we both were experienced in and we started to discuss mental health under one of the services called education and information or consultation and information, which had an animated film and at the end of it, the statistic read, there are more people occupying mental health beds than all other diseases combined.

This was shocking to most of us. We never dreamed such a thing existed. Then we started thinking of all the people in the streets who should have been in beds and it was even larger.

We began a series of seminars in which we discussed mental illness under the leadership of two psychiatrists and a psychologist, Dr. Maimie Clark. From that, we had about 65 people participating in a 12-series seminar, we began to learn about mental illness and health and the effect it was having on people in general. It was about this time that we learned about the projected mental health center for our area.

It all fitted in. This is why we tried to have an input, based on what we had been learning through our consultation and education programs. We had spread it throughout the community among teenagers as well. We set up a series of seminars with teenage clubs, which were very productive, with some adult input.

We held a workshop with discussion leaders, composed of people who went through our program. They were all discussion leaders on mental health, and what have you.

We were not successful in getting our ideas put across to the projected sponsors. We were told, "This is not mental health. These are social problems." We insisted they were mental health problems. We insisted if a person had on a tight shoe, his mental stability is affected also, especially if his feet was hurting.

A conflict developed, and in the end the community, under the Mental Health Act, rebelled and demanded the right to develop its own mental health service program and center. Because of certain people being in positions at that time, especially the commissioner of the New York State Department of Mental Hygiene and the leader of the NIHM region. And because they understood our position, they gave us terrific encouragement. They were first to recognize what we were trying to do and the first to give us recognition as an agency to develop the mental health center. In the meantime, this community had been working out of members' houses late into the night putting together a program of the proposal of the services it would like to see developed in the area. It was truly a community thing.

The task force developed a program, would come to a meeting and read the outline of what they had, there would be criticism from the meeting and back again to put the ideas across until finally we put together a proposal of the services we would like to see in the community, then we proceeded to demand that that proposal be accepted and late we began to develop the mental health project.

We proceeded toward our goal and again because of certain people in certain key positions and not meaning to embarrass anyone, I would like to name Dr. Miller, who was of terrific assistance, although he was not present there.

I would like to add the now commissioner of the Department of Mental Health, Dr. Christmas, was not in the position she is now, but she was participating in what we were doing. This was an encouragement that led us to think we had someone who would be useful and responsive to what we were trying to do despite the fact that the professional community in general was not in approval of us. Many times, people though we did not know what we were doing, and there are some current situations like that.

In many instances, we did not know what we were doing, but we knew what we wanted and we would know when we had it. That is what it was all about.

Well, the end result is that we now have the only, so far as we know at least, the only mental health center, and we can call it that now even though it is not officially named, that has a program developed by the community and a staff that has been hired by the community and is responable to the community, I think, in the country, possibly in the world.

You can believe what our director has told you. It is working. It is not directed to mental illness alone. Dr. Paster did not say last year the council sponsored two block parties. It was instrumental in assisting other block parties.

One of its projects now is getting people interested in co-op buildings through other sources we have and moneys available to them.

We feel that the community has now begun to realize there is something it can do. It does not have to take what is left at all times. Again, we were lucky when we came up with a person with the sensitivity of our director, Dr. Paster. By the way, she is not the first director. We were not as successful with the first one. This is also along the lines of one of our frustrations, and one of the things that could have blown what we were trying to do. It gave us a black eye, saying we were nonprofessionals saying he, a professional, does not know what to do.

Let me say for the record, we did not say that our former director didn't know what he was doing. He may have known very well what he was doing. We said he was not doing what we wanted done. That is what happened. So, this is a community that knows what it wants and it is proceeding in that direction.

I can only say here that possibly we have been lucky. Again, in that we and certain people in key positions who recognized what they were doing, were sensitive to us and gave us the encouragement that was needed to get to where we are now.

Thank you.

Dr. MILLER. Thank you very much. I think the record will show the closer we get to the center in human terms the more meaning it has. This may turn out to be one of the richest testimonies this congressional committee will have the opportunity to consider.

I also note that both of them were saying as others have said in describing something of their own experience that the process of participation in itself was health-giving, and we are talking about a living organism and not something that is fixed but is changing, growing, struggling, flourishing.

The hour grows late. There are two more people I would like to call upon. It is now 11:52. I am told that we must adjourn this part of this session at 10 after 12 and just before that I want to make an announcement about this afternoon's session and further discussion.

I will have to ask the next two speakers if they would try to limit themselves to 7 or 8 minutes each if they can. I would like to call now on Dr. William Hart, who is the director of the Rochester, N.Y. Mental Health Center and I believe someone will be speaking for the National Association of Community Mental Health Centers. Dr. Hart.

STATEMENT OF DR. WILLIAM HART, DIRECTOR, ROCHESTER MENTAL HEALTH CENTER, ROCHESTER, N.Y., IN BEHALF OF THE NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS

Dr. HART. I wish to thank Congressman Symington and Congressman Hastings for their able replacements. I think the previous speakers have really given the guts of the issue and I would like to add what I think are some of the technical issues we have to get to. As mentioned, I am director of the Rochester Mental Health Center and am representing the National Council of Community Mental Health Centers.

The Rochester Center is old as centers go. We are now in our 7th year of operation. In response to one of Congressman Hastings' questions earlier, this year, I believe we will run about 50 percent of our budget income, from medicaid. I don't know what the percent is throughout New York State but I guess it is getting up to that level. It may be that the center has to be in operation sometime before it does get to that level. I don't know why there is such a low amount across the country other than the length of operation and the way some States handle it. Along that line, our grant is down to about 10 to 12 percent so when you look as to where we are getting more Federal money, medicaid, probably accounts for 25 percent of our Federal funds while only 10 percent is via the categorical grant which I think may lead some to look to the future in terms of national health insurance and other methods of funding. As far as the mental health center is concerned, next year is our last year of funding and after that we could get along without the direct categorical grants.

In terms of the mental health movement, I think it is very important that the Mental Health Act be continued. I think it is absolutely necessary that grants be available for the development of new centers. I think without the Federal money the new centers will not develop. The Federal money is a third force in the community and creates an impact to develop idiosyncratic services to meet the needs of a particular community. Also, if new centers do not develop, if you look at New York State we are about 15 percent covered with new centers, but if new centers do not develop present centers will have a tendency to wither and die, and become quite a different thing from what they are. I do not think the present centers, because we are small in numbers, when you look at the whole country, can maintain the impetus for the mental health of the community and what it means.

Also the length of the grant should be extended to 11 years from 8 years to bridge to the national health insurance. Even though the centers in existence are small in number and cover a small percentage of the United States I think it is important they be preserved as the new centers come into being. The National Council of Community Mental Health Centers has a complete plan and outline of what they feel should be in the bill and to which I ascribe and copies are available of this. I think that the Federal money again might be characterized as preserving the independence of the centers. The Federal money has really allowed the development of voluntary nonprofit, nongovernmental centers. This is not attacking the Department of Mental Hygiene, or the city of New York in their operation, but I think their operations are strengthened by an independent agency that vies with them in some sense of the word, and in the long run strengthens them also.

Very briefly concerning unified services, I am sure the centers will, in the long run, have a very beneficial broadening, decentralizing effect on the implementation of the Unified Services Act. I think the kind of consultation and information from the community that the centers can bring will be very important in the implementation of this.

Another brief point—HMO health centers in the future may be the major source of funding for mental health services. The funds may very well come through health centers. Health centers in general

have an option as to mental health services, and I think it is very important that mental health centers begin negotiating with these HMO's, these health centers, so we do develop mental health services there and have income in that way. I think if it is looked at carefully, the centers are in a much better position to negotiate with health centers than other agencies that are in existence.

I know that in my current negotiations I almost scared the director of the health center off when I said I was getting community chest funds. I did not get to the point that I was getting Federal, county funds. That might have ended it there. In any event, I think it is a very important bridging.

Congressman Hastings' district covers the poorest county in New York State, Allegheny County. Categorical grants are meant to meet the needs and carry the services to people who can't get services, the poor. They are meant to develop different systems of delivery that fit into communities as we have heard before. I think it is important for Allegheny County, for the continuance of the Community Mental Health Centers Act. One further point is I think as centers grow older, as they have been around longer, there will be a need and a demand for them to develop services in rural areas or areas outside of their home. We have had some experience with this in Wayne County which is a poor county, east of Monroe which is relatively affluent. I think the structure and form of the service that develops there might be quite different than the present mental health centers. I think in terms of Allegheny County that this is an area that we might well eventually look into maybe not for the development of mental health centers but some type of mental health services.

Finally, as director of mental health services, I figure I spend around $100,000 a year in regulatory agencies. I think it is very necessary that there be a central movement toward centralizing these so I don't spend $100,000 on site visits and this type of thing that takes away from patient care.

From this standpoint, I propose that the comprehensive health planning of the agency become the major agency and that other agencies piggyback on that.

Finally, there are several other points and my time is up. I think on the whole issue of the Federal money that it should continue to continue the impetus of the community mental health centers movement which I think is the first movement in a long period of time to radically change mental health services.

Thank you.

[Dr. Hart's prepared statement follows:]

STATEMENT OF DR. WILLIAM T. HART, DIRECTOR, ROCHESTER MENTAL HEALTH CENTER, ROCHESTER, N.Y., IN BEHALF OF THE NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS

The continuation of federal support via the Community Mental Health Centers Act is necessary until National Health Insurance becomes a reality. I would recommend at this time that the present eight year limit on funding of Centers be extended to eleven years. Also, there should be a continuation of new Center funding so that more Centers can be developed. The complete phasing out of federal "seed" money can have a disastrous effect on a community. Federal support can build up a program that cannot be supported in its full form by local funds or cannot be supported at all. This program, when it has failed, creates a great deal of stress not only on the persons to whom the program was directed,

but also the agencies that were administering the program. The principles that I am going to speak to below, although directed to the Community Mental Health Centers Act, should also be woven into any National Health Insurance that is made into law.

The National Council of Community Mental Health Centers have a detailed blueprint for a new Community Mental Health Centers Act. I believe that you have it, or if not, I can see that you are provided with it. I do not intend to cover all are facets of the Act as proposed by the National Council, but will speak to certain philosophical underpinnings for the Act that have become apparent to me as the Director of a Center. The Center came into existence January 1, 1967 and I have been the Director of the Center since that time.

Categorical grants were devised to meet neglected needs in human areas that local communities for some reason had not attended to. Without continued federal support, I feel that at this point of Center development we would revert and these needs would again become neglected. Revenue sharing that theoretically should help satisfy these needs actually enforces the "old" attitudes of the community by coming through traditional channels. It is molded by the traditional attitudes of those channels. Categorical grants, however, addresses itself directly to the specific unmet need.

It is necessary to continue federal support to preserve the independence of the Mental Health Centers that offer a varied spectrum of services that are geographically accessible and available to all with markedly decreased stigma as compared to the older services. The Centers have moved services from inpatient services at State Hospitals to outpatient services within the local community and to day care and inpatient services. This occurred when the patient impinged upon them to such an extent that they could no longer tolerate it. I see no evidence that the public at this time is any more willing to buy more progressive services such as outpatient services than they were in the past without the stimulus of federal support.

The State Hospital system is very large and powerful and tends to reabsorb patients and services and staff back into itself. In New York State, $580 million per year are spent on State Hospital services versus $10 million State dollars going to Mental Health Centers. Without continuing federal support, the difference in funding would tend to reduce the flexibility that the Centers have. Patients and staff do not want to leave the State Hospital system. The patients and staff are used to a way of life and without an outside agency to stimulate the painful change it will not be done. The Unified Services Act recognizes this and attempts to provide this outside stimulus.

Public opinion resists the movement to a new system of delivery. This opinion will impinge at the many points where revenue sharing comes down the pipeline and prevent a change in the system. Many relatives have developed a habit of hospitalizing a certain member of the family and will have difficulty breaking this longstanding tradition. Large hospitals have become a very important economic resource to the area in which they are established. A short time ago I heard a legislator attacking the closing of a large State facility in the area in which he lived and the adverse economic impact it had on that area. Mental Health Centers provide for the development of other types of services into which this staff can move and alleviate the economic impact upon both the staff and the local community.

The Center is idiosyncratic to the area it serves and needs to be responsive to the peculiarities of both the community and the staff that it is able to recruit. The federal grant so far has provided for more variability and more responsiveness to local communities than would have been possible without it. There certainly needs to be central minimum standards but not complete control of a program that makes it conform to procedures that may be irrelevant to the area in which it is operative.

There should also be provision in the law for coordination of the services other than Community Mental Health Centers, probably through comprehensive health planning. In New York State, for example, no Department of Mental Hygiene programs go through comprehensive health planning. So in our community, roughly half of our services go through CHP and half do not.

Also, coordination is necessary to prevent the increasing paperwork concerned with regulations from overwhelming an agency. I spend a minimum of $100,000 a year or almost 10% of my budget satisfying regulatory agencies. This money, of course, comes out of patient care, reducing the amount available. Recently, I had 3 separate agencies mandating me to fill out 3 separate forms

that were almost exactly the same. I felt that it would cost me $6 to $7,000 a year to comply with this request. However, after some correspondence and a meeting, we were able to reduce this markedly. The problem still remains a difficult costly one.

The Unified Services Act that was just passed by the New York State Legislature will in the near future begin channeling some of the $580 million institution money and probably eventually all of it through local government for mental health care. There are no specific references in this Bill to working with Health Centers and it is important that the Mental Health Centers remain independent to negotiate with the developing HMO's so that they develop mental health services. This is a difficult problem to integrate these services in that the HMO is trying to develop services with the least expense to the enrollee and leaving out mental health services would reduce this cost. In my experience they are somewhat cautious about negotiating with a voluntary non-profit organization much less a State organization. However, for effective patient care there has to be integration of both the State Hospital system and the developing health center.

The provision for the continuing development of new Centers is another very important point in the renewal of the Community Mental Health Centers Act. At the present time only 15% of the population of New York State is covered. Unless this 85% is gradually covered, the patient pressure on the existing areas covered would lead to the demise of the Community Mental Health Center, to say nothing of the inequity of the situation. The present Centers can lead to the extension of services to areas outside their catchment area in areas that otherwise might not be able to develop independent services. For example, we are in the process of developing consultation services to a rural Center in Wayne County. There are no services there and I do not think they could be developed independently.

Consultation and education are difficult to provide for but very necessary components of a mental health center. With the developing system of health centers providing only payment for direct care, this mode of service will not be acceptable to them because services will go to other than their enrollees. Therefore, there must be some sort of a capitation method of payment for consultation and education possibly with State matching.

Finally, there should be direct grants for training all types of personnel such as psychiatrists, psychologists, social workers, recreational therapists, etc. The University is having a great deal of difficulty financing their training programs and if the Mental Health Center could be a source of funding, albeit modest, this would attract trainees to the program and so expose them to community mental health activities. The community mental health system of delivery is markedly different and when we hire personnel we have to essentially retrain them to be able to work with us. I think the major value of funding that would attract trainees to Mental Health Centers would be to expose them to a service-oriented delivery system. This would then have impact in how they would practice in the various settings that they went into and in turn have impact on those settings.

In conclusion, the Mental Health Centers have made a modest beginning towards the development of a new delivery system to meet the needs of the population rather than small isolated groups. To maintain the impetus of this beginning it is necessary for funding that will sustain the existing Centers until National Health Insurance is available and to fund the development of new Centers to reach the total population.

Dr. MILLER. Thank you very much. I am pleased you mentioned the HMO's. I only hope that as HMO's develop, they will emulate what I consider the essential dimension of mental health centers: namely, that they will be responsive to and work with whole populations, rather than just those people who register with them.

I think that approach would make possible the kind of collaboration and synthesis which you described.

I might also say for the record that every county in New York State, including even Allegheny, has a county governmental department of mental health, retardation, and alcoholism. I think that gives us, with Federal legislation helping us, an opportunity really to extend to every citizen the kind of program which we have heard every citizen in the State has a right to.

I would like to call last and perhaps not in that context quite appropriately, Mr. Carman Santor. Mr. Santor is the new president of the New York State Association of Community Mental Health Boards, which are for the counties and New York City the local governmental bodies which bear responsibility for the development of mental health, retardation, and alcoholism services. Mr. Santor.

STATEMENT OF CARMAN SANTOR, PRESIDENT, NEW YORK STATE ASSOCIATION OF COMMUNITY MENTAL HEALTH BOARDS

Mr. SANTOR. Thank you very much, Commissioner Miller. I will be very brief. Following some of these most moving presentations, informative and even provocative, I would like to express appreciation to Congressman Symington's and Hastings' requesting the House Subcommittee on Public Health and Environment for holding these hearings.

The Congress recently voted to extend the act for 1 year, one purpose being primarily to evaluate the continuing need for community mental health services center legislation. At the recently held annual meeting of the New York State Mental Community Centers Board, at Nyack, N.Y., the following resolution was unanimously adopted:

Whereas both Houses of Congress overwhelmingly voted to extend the community health centers for another year, and

Whereas continued responsibility and fiscal support for existing and new mental health programs are desirable and essential to meet the need of the American people—mental retardation, drug abuse and children's services, therefore, be it

***Resolved*, That the New York State Community of Mental Health Boards go on record as strongly supporting the enactment of H.R. 7806 and Senate 1136.**

Copies of this resolution be promptly forwarded to President Nixon, Health, Education and Welfare Secretary, Caspar Weinberger and the news media.

As the newly elected board of an organization co-sponsoring the "1973 conference on community mental health services," I feel it is both a privilege and responsibility to attend and participate in this important event being held today.

One of my first important official duties upon assuming this statewide office was to be invited by you, Commissioner Miller, to attend and actively participate the day that many employees were recognized from the State hospitals and the State schools.

It was very moving and it gave me a chance from grassroots as a consumer producer to meet the people "where the action is."

I also felt it very rewarding to also accept Governor Rockefeller's invitation to participate in a unified signing bill, a hallmark in mental health service legislation which you helped engineer through with a lot of hard work.

As we are all aware, the purpose of this bill is to provide unified services, which will grant to the State and the communities opportunities to engage in joint planning activities. It is hoped sincerely that we will have the necessary leadership and financial support so that the needs of the mentally handicapped will be continuously met, nationwide and we will have a true partnership as well as having the consumers and the volunteers and the paraprofessional's contribution so that we can better utilize and strengthen our human resources in this technological and space age of ours.

Again, I would like to thank Congressman Hastings for inviting me to participate on the most important and timely occasion on behalf of the mentally disabled.

Our New York organization of mental health boards will continue to be vigilant in its efforts at all levels of government in these most urgent and pressing matters involving our citizenry.

Thank you.

Dr. MILLER. Thank you very much, Mr. Santor.

I thank all of you who have testified, all of you who have come. I apologize that there has not been more opportunity for discussion this morning, but there will be this afternoon. I thank my colleagues at the head table. I am sorry they did not have a chance to speak further this morning. We are especially appreciative to Congressman Symington and Congressman Hastings, for holding this extraordinarily rich hearing which will provide a report to the national Congress of what people in New York State are thinking and doing. Many thanks.

[The following statement and letter were received for the record:]

STATEMENT OF THE AMERICAN OSTEOPATHIC ASSOCIATION, THE AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, AND THE AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

The American Osteopathic Association (AOA), the American Osteopathic Hospital Association (AOHA), and the American Association of Colleges of Osteopathic Medicine (AACOM) are compelled to take this opportunity to submit for the record their views on continuing Federal assistance to the development of Community Mental Health Centers. In this regard, the Associations wish to express their grave concern over the fate of the Thousand Hills Community Mental Health Center (THCMHC), which, upon its completion will provide needed health services to approximately 200,000 people in Northeast Missouri.

Plans for the development and implementation of THCMHC were initiated by the Kirksville College of Osteopathic Medicine (KCOM), Kirksville, Missouri. This center is geared to provide both inpatient and outpatient facilities and services for comprehensive mental health care for an 18 county catchment area with KCOM being located in the center of said area. THCMHC is to be located on a site owned by the College, immediately adjacent to the Kirksville Osteopathic Hospital.

In early 1969 KCOM applied for a federal grant to assist in the construction of THCMHC, and a Federal Construction Grant of slightly over $600,000 was awarded. The projected cost of the facility is $1.2 million. KCOM has accepted the responsibility of raising $200,000. An additional $400,000 is available from the Commerce Bank in Kansas City contingent upon a Federal Staffing Grant. Therefore, an appropriate grant application has been submitted to the HEW Regional Office.

Unfortunately, the recent decision by the Executive Branch to cut staffing funds from the budget, is in actuality negating the essential objectives of the original legislation. In taking this action, the Administration has stressed the availability of state funding through the program of state revenue sharing. In fact however, funds for this needed health service will not be forthcoming from the state; thereby nullifying the highly documented need for such a service.

The problem is further compounded due to the fact that experience has shown that it normally takes 8 to 10 years of operation, before patient fees and third party payments can meet normal operational expenses.

The need for this facility is exceedingly obvious. In excess of 10,000 Northeast Missourians will be affected by some form of mental illness in the forthcoming year. Whether it be from anxieties and fears, tensions resulting in alcoholism, drug abuse, or personal tragedy, these problems are as critical as any terminal disease; for, in fact, they affect the very moral fiber of our country and cannot be ignored. Unfortunately, the closest mental health center in the area to be served is over one hundred miles in distance. The availability of such a center would afford the 19,000 potential patients of THCMHC with their right to receive immediate and proper care in their own community in addition to a tax advantage of untold thousands to the State and the families to be served.

It should be noted that a majority of the necessary professional and supporting staff needed to adequately man such a center are already functioning on the KCOM faculty. The availability of three full-time psychiatrists, four psychologists and qualified persons in many other related disciplines, readily enhances the early effectiveness of such a center. Through KCOM's Residency Program with the State Division of Mental Health, the college is assured of additional professional personnel required to staff the center.

Specifically involved in the outpatient care, will be the Rural Extension Outpatient Clinics of KCOM. These clinics will function as a magnification of the outpatient services provided by THCMHC psychiatric teams and/or rural extension personnel itself. Through this activity, THCMHC will be able to reach all sections of the catchment area thereby providing most of the health needs which rural areas have been lacking to date.

The AOA, AOHA and AACOM are of one mind regarding the aforementioned mental health needs of the rural "breadbasket" areas of our country. In our opinion, the responsibility of the Congress is clearly understood in such matters. We understand that the aforementioned is but one example of an attempt to meet such needs and is currently in jeopardy of missing its goal.

We firmly believe that the best interests of the Nation will be served with the continuing development and operation of Community Mental Health Centers. It is the goal of our entire health profession to provide each and every individual with the kind of health care he has come to expect and to help ordinary people with extraordinary problems, but we cannot accomplish this alone.

AMERICAN NURSES' ASSOCIATION, INC.,
Kansas City, Mo., May 4, 1973.

Hon. PAUL G. ROGERS, *Chairman, Subcommittee on Public Health and Environment, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, Washington, D.C.*

DEAR MR. ROGERS: The American Nurses' Association is pleased that your subcommittee is holding oversight hearings on the important issue of Community Mental Health Centers. Those of us familiar with the effectiveness of the programs in such centers were very disturbed to find that the Administration opposes renewal of the Community Mental Health Centers Act while at the same time they stress the success of the program.

As has already been pointed out by many, few third party payment plans now provide coverage for out-of-hospital mental health care. Lack of federal funds to promote the establishment of community mental health centers in those areas not yet funded will deprive many of the benefits those centers provide.

The Community Mental Health Centers Act of 1963 and its successors was a major step forward to attack the serious problem of mental illness in a humane way. The opportunity of receiving care close to home, without the disruption of leaving family and friends as occurs with hospitalization, is a great improvement. In the long run, of course, this type of care will be less costly in dollars and in human suffering.

Previously, we have pointed out that time was required to prepare settings, communities and health practitioners for the most effective functioning of the new centers. It has now been shown repeatedly that the new approaches are being implemented successfully and the practitioners now being prepared are ready to function well in those mental health centers.

One of the strengths of the center concept is the true interdisciplinary team functioning of the staffs. The traditional barriers between professional staff members in terms of roles and functions have been eliminated in many centers. In this situation, the skills of each team member are used much more effectively.

Community mental health nurses with appropriate specialty preparation at the graduate level are successfully providing individual, group and family therapy and are providing liaison services to general and psychiatric hospitals as is needed. Their roles have proven to be vital and varied.

Because nurses are generally oriented to the relationships of physical, psychological, environmental and community factors one to the other, this new role is a very effective utilization of their preparation and skills.

Unfortunately there are some mental health centers that still do not utilize the full potential of psychiatric nurses. There appears to be almost a geographic

difference in philosophy within the psychiatric field as to the types of care that are most effective and the centers do, of course, reflect the community that they serve.

The programs educating health professional and allied health workers have changed in recent years to better prepare students for these community-focused programs. Now that there are operational community mental health centers available for learning experiences and experienced role models for the students to work with, the outlook for the future is encouraging.

We will address ourselves more specifically to this issue when new or renewal legislation is introduced which we hope is in the very near future. A program with the support and acclaim of the public, the health professions, the Congress *and* the Administration must not be allowed to terminate when its job is only partly completed.

I hope this statement can be included in the hearings record.

Sincerely,

EILEEN M. JACOBI, Ed. D., R.N.,
Executive Director.

[Whereupon, at 12:15 p.m., the subcommittee adjourned.]

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